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EDITORIAL

During the last year the Publications Committee of the British Institute of Psycho-Analysis has considered possible improvements in the form of the *Journal* to keep it in line with the wishes of readers and modern publishing trends. It was thought that the present format was acceptable except for the cover.

The new design introduced with this issue will, it is hoped, meet with our readers' approval. The main changes are rearrangements rather than alterations, and are intended to facilitate the assimilation of the information given while at the same time achieving a more pleasing appearance. Whether or not it is a result of the gradual supersession of the classics by the natural sciences in modern education, it seems to be the case that few readers feel at ease with Roman numerals above a point which has long been passed by the *Journal* now that it has reached Volume XLIV. These will therefore be replaced by Arabic numbers. In response to readers' requests, there will be a few minor changes, e.g. the Harvard convention will be adopted in citing references.

The Committee has also decided to revert to the original practice of publishing the *Journal* in four quarterly parts each year. A few years ago bi-monthly parts were introduced in the hope of achieving speedier publication. Experience showed, however, that in most years there had to be a combining of parts to allow for the various special features which the *Journal* covers, e.g. the International Congresses, Bulletins, and Lists of Members. It is hoped that the change to quarterly issues will permit these special numbers to appear without too much dislocation of the publication schedule.

Each volume will continue to be of the same size as in recent years, giving a yearly average of about 500 pages.

THE INTERNATIONAL JOURNAL OF PSYCHO-ANALYSIS

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Part 1

SYMPTOM FORMATION AND CHARACTER FORMATION¹

By

JEANNE LAMPL-DE GROOT, AMSTERDAM

I. Introduction

To deal with this very broad topic in a single presentation seems impossible. It is not my intention to focus on one clinical constellation. Apart from theoretical reflection, there is a practical consideration, namely the fact that we hardly ever meet with a 'simple' neurosis in our patients. I will therefore try to present a few aspects of the general theme. I do not intend to give a systematic presentation, and in order to make my points I shall elaborate upon themes not strictly falling under the title of this symposium.

It is true that Freud started his psychological investigations with hysterical patients. However, it soon became clear that most patients reveal a mixture of symptoms belonging to different neurotic pictures, for instance a combination of hysterical and obsessional-neurotic, of phobic and depressive constellations.

Freud discovered that the foundation of obsessional neurosis was a childhood neurosis of the hysterical type, and established a close relationship between the symptoms of conversion-hysteria and anxiety-hysteria or phobia, as well as between those of phobias and obsessional neurosis. Moreover, in a number of cases that could be labelled as mainly hysterical neuroses we meet with character traits of a definite obsessional neurotic origin, and the reverse is encountered as well.

Other observations teach us that many patients cannot be classed in a special neurotic category. They show various disturbances: symptoms as well as inhibitions, depressive states, etc., which we usually term 'neurotic disorders', not to

mention those with more severe disturbances such as borderline cases, psychotics, and delinquents. In the analysis of neurotic patients we often meet with psychotic mechanisms that may manifest themselves for instance in a kernel of delusions. In addition a mixture of symptoms and character distortions reveals itself in many cases.

In view of these various considerations I intend to try to highlight some aspects of the processes involved in the genesis of symptoms and character-traits, especially from the more recently developed structural-dynamic viewpoint. Before embarking on this endeavour, I want to point out a peculiarity of our topic. Symptom formation is a psychopathological phenomenon, whereas character formation is in itself a 'normal' developmental process. However, as psycho-analysis has shown that there is an easy transition from 'normality' to pathology, and that mental processes are more easily studied in the context of pathological phenomena, I will stick to the traditional line of using the manifestations of abnormal development in trying to describe some aspects of what may be termed a 'normal' character formation and personality development.

II. Symptom Formation

During the development of psycho-analysis, Freud used different terms for the description of symptom formation. I will cite a definition given in 'Inhibitions, Symptoms and Anxiety' (1926, p. 91):

'The main characteristics of the formation of symptoms have long been studied and, I hope,

¹ This paper, together with Dr Arlow's paper in this issue, will be the subject of a discussion at the 23rd International Congress of Psycho-Analysis, Stockholm, July-August 1963.

established beyond dispute. A symptom is a sign of, and a substitute for, an instinctual satisfaction which has remained in abeyance; it is a consequence of the process of repression. Repression proceeds from the ego when the latter—it may be at the behest of the superego—refuses to associate itself with an instinctual cathexis which has been aroused in the id.'

Freud elaborates upon the subject in many very important directions. I mention only two of them.

(i) He points out that repression is only one of a variety of defence mechanisms, though it has a special place among them and a special relation to hysterical neuroses, without being the *only* mode of defence in this disease.

(ii) He reconsiders the problem of anxiety, conceiving of it as an ego-activity signalling a danger situation, from without as well as from within.

The first statement is an enlargement, the second a modification of former theories. Both have been of great significance for the stimulation of the development of ego psychology in more recent times.

When we now consider the coming into being of a symptom, we meet with Freud's early discovery of a conflict between the ego and an instinctual id-impulse that cannot be satisfied. At that time the ego was conceived of as an entity opposing itself to the id because it had to mediate between the person's needs and the demands of the environment. In later periods Freud described the ego as an organization of different functions, and drew attention to the influence of the conflict on the ego organization. He spoke of an impoverishment, an impairment, a distortion, of the ego.

We often encounter the view that a conflict is a *pathological* phenomenon. I want to stress explicitly that conflict is a normal event in the dynamics of living beings. It is inherent in the life-process. Every creature experiences clashes with its environment which it has to encounter in order to preserve its own existence. In the highly differentiated and complicated structure of the human mind conflicts not only originate from an encounter with the environment, but to a great extent they take place between internal sub-areas. The process of development is centred around and stimulated by inner and outer conflicts. The decision whether a 'normal' solution of a conflict is achieved or whether a symptom or some other pathological outcome finally emerges, depends upon the intactness of an ego-capacity, the integrative or harmonizing

ability. In my paper on 'The Superego and the Ego-Ideal' (read at the Edinburgh Congress, 1961) I called the original and basic function of the superego an agency of restriction, that of the ego-ideal an agency of wish-fulfilment. I now want to add that I consider the basic function of the ego to be the synthetic or integrative one. The ability to achieve harmony is the outcome of a complicated process in ego development. A number of achievements are necessary in order to enable the ego to use the basic function in a satisfactory way. If the ego is capable of solving the conflicts, in synthesizing the different demands made upon the personality (the 'self') from the inner as well as from the outer world, we speak of a 'normal' psychic process. This means that the ego is able to allow the personality a sufficient satisfaction of instinctual and affective needs without disturbing the relation with the environment in agreement with superego and ego-ideal demands and without impairing its (the ego's) own capacities. This is in accordance with the pleasure principle or its modified version, the reality principle. It does not mean that conflicts are eliminated for ever from the mind. New conflicts continually arise, so that the integrative capacity has to come into action repeatedly. It is not a static but a dynamic process. Whether in a given situation harmony can be achieved through conflict-solving depends upon a number of factors, which can be brought under two headings: (a) the relative strength of the synthetic capacity (the economic aspect); (b) the mobility and the reversibility of the harmonizing process. The factors involved emerge from the different areas of the personality.

When we examine our patient's neurotic symptoms in the making, we observe an impairment of his synthesizing faculties. The patient starts by complaining of his symptoms, which he feels as alien intruders in his 'self'. He suffers from anxiety states, from obsessions, from depressive and other painful moods, and so on, which he is quite aware that he cannot escape. His incapacity to feel in harmony with his self is apparently a very painful experience. This state of mind does not imply that the capacity for integration is totally and for ever eliminated; on the contrary, its working is apparent from the fact that in the long run the ego tries to integrate the symptoms into its organization. But it has failed to operate in a conflict-solving way. The conflict-causing id impulses had to be warded off (or repressed);

they are now inaccessible to the ego, which is unable to influence them in any way. As the drive-impulses constantly put pressure upon the ego demanding discharge, the latter agency must strengthen its anti-cathexis by using new defence mechanisms. The defensive procedures require energy that is withdrawn from other activities, including autonomous, ego-syntonic performances. The result is an inhibition, an impoverishment of the ego. A further consequence is a reduction of pleasure gain. A substitutive masochistic satisfaction from suffering and a secondary gain from illness are now the only modes of gratification available, so far as the diseased part of the personality is concerned.

Before turning to the examination of the defensive processes, the origin of the mechanisms of defence and their influence upon ego-development, I want to indicate briefly the factors Freud made responsible for the failure to solve conflicts and to prevent neurotic conditions.

In analysis neurotic symptoms can invariably be traced back to an infantile neurosis. As the little child's ego-organization is still in a state of immaturity, it is a 'loose' and 'feeble' agency which cannot deal appropriately with the demands of the drives. Drives and impulses are perceived as dangerous and have to be warded off. Anxiety is raised by the ego as a signal, indicating that a danger is present and that the ego has to take counter-measures. Though in principle a person can take refuge in 'flight' before external dangers, such as over-severe demands and punishments, the child is too dependent upon his environment to do this. Therefore he has to undertake similar defensive action against both environmental and inner demands. When the parents' prohibitions have become internalized and laid down in the superego, the ego is still more intimately influenced by them and can take refuge exclusively in warding-off mechanisms. In connexion with these facts Freud (1926) names three prominent factors that play a part in the causation of neuroses:

(a) A biological factor, the long period of helplessness and dependence during childhood.

(b) A phylogenetic factor, namely the interruption in the development of the drives during latency ('*zweiseitiger Ansatz des Sexuallebens*') which leads to a genuine incapacity for satisfaction of the needs and impulses in the first years of life.

(c) A psychological factor, the differentiation of the mental apparatus into id and ego (and

superego), due to the necessity of dealing with the influence of the external world.

Here I would add that the third point (c) was later revised to show that the differentiation of id and ego was an inborn maturational factor affected and influenced by environmental stimuli.

I think we all adhere to Freud's statements when we examine the material presented to us by our patients. The three factors mentioned can help us to understand a good deal about the causation of symptoms, in so far as they explain the vulnerability of the child's mind. There are many children, however, who do not show neurotic symptoms in their first years of life or who 'outgrow' their slight infantile neurosis and do not become neurotics in later life. We must therefore look for special factors which make for neurotic development or for 'health'. One important question is: Which factors cause a lasting impairment of the ego's integrating capacity?

It is self-evident that we have to look for these factors among the three agencies of the structured mind and their dynamic interplay under the influence of the environment. Dynamics can only be understood when we consider genesis, course of development, and economic (quantitative) proportions. The magnitude of all these different relations is so confusing that we shall have to simplify by merely sketching some facets of the various processes.

Our knowledge is most advanced as regards the maturational process of the drives (the id). A smooth course for this process is certainly dependent on inborn peculiarities of the drives, for example their relative strength, which may lead to acting out and anti-social behaviour, quantitative relationship between sexual and aggressive drives, their fusion and defusion, important in depressive and paranoid states, and perhaps other factors, such as flexibility, rhythm, etc. However, the course of development is also strongly influenced by the attitude of the environment, by the way the mother responds to the infant's needs. The question to what extent she is able to guide the development into favourable paths can be decisive.

The same is true with regard to the development of the ego-functions and their organization into a structured part of the mind. Though psycho-analytic ego-psychology has made great advances during recent decades (Hartmann, 1939, 1950; Rapaport, and many others) it is still not far enough advanced to enable us to give an exact survey of the development of the

different functions in chronological order. I will limit myself therefore to the description of some well-known facts and a few tentative suggestions.

Let us start by examining the 'autonomous' ego-functions (Hartmann, 1939, 1950). Ego-development is a maturational process dependent upon bodily growth as well as upon innate 'anlage' factors. At the same time it is a learning process influenced by the environment. The mother may stimulate the development of certain ego-functions, as she stimulates drive-development. On the other hand she may hamper the developmental processes, in connexion with peculiarities of her own personality and character, and her affective relationship with the child. (See, e.g. Provence and Ritvo (1961)). The outcome can be a fortunate, smooth, as well as an uneven, disturbed, growing-up of the child.

We assume the mental ego to emerge from the 'body-schema' (or body-ego) (Greenacre, 1960; Winnicott, 1960, *et al.*). According to Winnicott the infant perceives his own body as a whole in the second half of the first year. So the basic function of synthesis is already present in the body-ego at an early date, maybe consequent on the binding, integrative tendency inherent in the life-process. The differentiation between the self and the outer world probably begins in the first six months, though in a very incomplete way. Even when the child perceives his body as a whole, he still at times experiences a oneness with the mother. The newborn perceives stimuli from within as well as from without. So perception also is one of the first ego functions to develop. At what exact time memory-traces begin to be laid down we do not yet know; probably as early as the first months.

Bodily sensations give rise gradually to motor activities, which develop into purposeful actions, e.g. crying, grasping, crawling, walking, etc. Memory traces, which in the beginning are laid down as images, begin to be connected with words after the child has learned to understand speech and gradually to use words himself, at the end of the first year and during the second. Learning starts with imitation. This is specially observable in the development of speech. Vocal communication without word-symbols is present in the human infant as it is in the higher animals. But words can be learned only by *imitation*. In addition, connected with the *emotional* ties to the mother, the mechanism of identification begins to be used in the (normal) process of adaptation, precipitating the learning of speech as well as of other functions. Here we meet with an example

of the mutual influence of emotional with autonomous ego development. During the first years of life a number of other adaptational mechanisms and processes come into being. The complexity of the different interrelationships makes the child's ego a vulnerable organization and often interferes with the process of integration. In addition, a complication arises when as an outcome of the oedipal situation the forerunners of superego and ego-ideal are internalized into one substructure of the ego. In a 'normal' case, however, we have to assume the existence of a basically integrated organization of the ego functions at the end of the oedipal phase. This does not, of course, mean that the learning (and developmental) processes have come to a standstill. Learning continues throughout life, and influences the dynamics of all vital processes. I now come back to the role of the ego in the various symptom formations.

During the pre-oedipal phase the growing, still 'vulnerable' ego meets with a number of danger situations in which it experiences anxiety. 'Dangers' come from the outer world in the shape of limitations of need satisfaction and of demands from the environment. They come from the internal world inasmuch as the child feels powerless to provide himself with sufficient satisfaction of needs. From the mother he fears punishment and loss of love; from the inner world it is the narcissistic injury of feeling powerless and of being threatened by id impulses that is experienced as an unbearable and inescapable danger. Now when the ego is not able to solve the conflict in a harmonious way, it has to take refuge in defensive measures, using several defence mechanisms.

We must, however, distinguish sharply between pathological neurotic defensive processes that lead to an inhibition and impairment of ego activities, and a sound conflict-solution that may leave its imprint upon the ego, but without impairing the ego's autonomous functions (in the 'conflict-free ego sphere', Hartmann). I suggest, therefore, the following formulation: If the capacity for integration *fails* to solve conflicts without damaging the ego, the impaired ego becomes unable to prevent several adaptation mechanisms from being drawn into neurotic defensive processes, and thus being employed as pathological defence-mechanisms. The latter, then, may in their turn cause damage to the ego-organization.

The following question here arises: What events are responsible for turning normal

adaptation mechanisms into defence-mechanisms, made use of in pathological processes? It may sometimes be difficult to decide whether we have to do with a 'normal' or with a 'pathological' process, because in a number of cases easy transition from a 'healthy' to a 'pathological' use of mental mechanisms is apparent. With hysterical symptoms, especially in conversion hysteria, a special defence mechanism, namely repression, is predominantly used. Is repression exclusively a pathological defence mechanism? We cannot confirm this. It is well known that (at least in our civilization) large parts of childhood experiences have become unconscious in individuals whom we consider to be quite 'normal'. Memories are repressed. In hysterical neuroses, however, a number of different ego functions have become involved and damaged; e.g. in hysterical conversion symptoms the employment of the motor apparatus may be paralysed, or the sensorial functions are disconnected, in some instances perception is eliminated, etc. Furthermore, the symptoms cannot be removed without special measures in a treatment situation. Apparently the ego is using the mechanism of repression, which includes an anticathexis against the repressed impulses. It has not succeeded in mastering anxiety and danger-situations sufficiently.

In phobias we encounter among others one special defence mechanism: avoidance. Do examples exist where we can consider avoidance of danger-situations, signalled by anxiety, as a 'sound' reaction? Apart from realistic dangers in the outer world which every 'healthy' person will try to avoid, we can, for example, meet with individuals living in special circumstances with whom certain id impulses, usually satisfied, have to be held in abeyance in consequence of these unusual circumstances. We do not call it pathological when the person in question avoids situations where these impulses are specially stimulated and apt to raise anxiety. All of us could give examples of such events, e.g. during wartime. In these cases, however, the avoidance remains restricted to the special situation, and as soon as the abnormal circumstances have ceased to exist, the avoidance will be removed also. Here too the mechanism served an adaptational process; it proved to be reversible, and did not involve other ego functions in a damaging way. With the phobic patient it is impossible to give up the avoidance; in trying to do so, he is overwhelmed by anxiety and

unable to have any kind of sound ego activity. Here, too, we have to assume an additional counter-measure against the id impulses from the side of the ego, that fixates the avoidance and makes it irreversible. The counter-cathecting activity of the ego is most clearly observable in obsessional neurotic symptoms (Freud, 1926). The immediate cause of this disease is the same as in hysteria, and exists in impulses of the oedipal situation, which cannot be mastered by the ego. As repression does not succeed in keeping the drive-impulses unconscious, according to Freud either because the genital drive organization was too feeble or because the ego began the struggle against the drives prematurely, namely during the anal-sadistic phase, the ego takes refuge in a number of other methods of warding off. First regression takes place, and impulses and fantasies now reveal themselves in an anal-sadistic shape. The ego defends itself against them with an anti- (or counter-) cathexis, e.g. in the form of reaction formations. Under continual pressure of the id the ego has to produce ever more defensive actions using such mechanisms as turning against the self, isolation, undoing, denial, etc. Many of the defensive actions are initiated by a severe superego and serve self-punishment. In serious compulsion neuroses more and more ego functions become gradually involved and damaged. The impoverishment of the ego is partly a secondary result of the struggle with the id. But the ego not only *opposes* the id, it also *participates* in the regressive process, and thus falls back upon earlier, more primitive modes of action. This is clearly observable in a regression towards magic thinking and magical acting-out. Removal of severe obsessional-neurotic symptoms belongs to lengthy psycho-analytic work, and in many cases the symptoms prove to resist any recovery, especially when intellectual understanding of mental connexions is isolated from emotional experiences and intellectualization is used in the defensive processes. We know that many of the reaction-formations represent exaggerations and distortions of character-traits. Cleanliness, orderliness, and economy are reaction-formations against the pleasurable impulses to smear, to mess, and to waste. They are considered 'normal' and valuable qualities. As we have already described character formation as a 'normal' process, we have to look for the boundaries between 'normal' and pathological reaction formations. I will come back to this point when embarking upon the study of

character formation. Before doing so, I want to examine some more defence mechanisms. Apart from regression and reaction formation, we meet in obsessional neurotics with *isolation* and *undoing*.

Isolation is a mental mechanism that finds its place in normality, e.g. in thought processes. Logical and scientific thinking has to isolate thought and to eliminate affect-laden representations ('wishful thinking') from abstract ideas. For abstract thinking neutralized energy is necessary; in wishful thinking drive-cathected energy is employed. Thus the two modes of thinking have to be separated, isolated from each other. Here too, however, the process (of isolation) can be abandoned at will, whereas in neurosis it has become rigid and unalterable. The same is valid for 'undoing'. 'Healthy' people often consider an action, as well as a thought which is a trial action, as unjust, whereupon they will try to undo it by a counter-activity. In our neurotic patients the process of undoing has acquired a compulsive character, and is maintained in situations where it is no longer realistic and appropriate. With paranoid symptoms we encounter identification and projection as defence mechanisms. Both are 'normal' adaptive methods in their origin. We have already mentioned the important role of identification in learning processes, as well as in mastering emotional situations. Projection is a 'normal' way of dealing with unpleasurable sensations in the infant, and it promotes the distinction between self and outer world. In delusions, however, both mechanisms have become fixated, unchangeable modes of reaction.

In defensive actions the ego may also make use of certain vicissitudes of the instinctual drives which come into being in the course of development. The 'turning inwards' of drive-impulses is a natural happening in the formation of the superego, when aggression is internalized. The process promotes adjustment to the environment. In pathological cases, however, the result is not a better adaptation but a masochistic mode of behaviour in consequence of a strong need for self-punishment. Here quantitative factors are decisive. Reversal of drive-impulses, e.g. from activity to passivity and vice versa, is continually happening. The ego makes use of it in a number of adaptational processes. In learning, for example, a passive surrender to the objects and to verbal or written instruction is necessary. The constructive assimilation of what is learned needs a good deal of activity. Fixation

of the one or the other tendency leads to pathology. Sublimation or neutralization of drives is of special importance in many respects. I return to this point later.

In summary we may say: Adaptation mechanisms can be employed in neurotic symptoms as (pathological) defence mechanisms. We have to consider the outcome of the process as 'health' when the mechanisms are made use of by ego activities in a flexible and changeable way. They belong to pathological phenomena when the process has become fixed and irreversible.

So far we have described merely neurotic disorders (the so-called transference neuroses). We assume that in these neuroses ego-development has advanced more or less 'normally' until the time of solution of the oedipal complex. In connexion with traumatic events (e.g. an overwhelming castration anxiety) a danger situation emerges, resulting in a neurotic defensive attitude on the part of the ego. The formation of symptoms is the outcome of this struggle, together with an inhibition of ego functions. A *secondary* consequence may be regression of ego functions to points of arrest in earlier developmental stages. Symptoms are signs of and substitutes for instinctual satisfaction. This is above all apparent in compulsive actions which can, for example, be substituted for masturbatory acts. Furthermore the pleasure principle reveals itself in a secondary gain of illness, in a narcissistic satisfaction by rationalization, magical thinking, and in fantasies of omnipotence, etc. The curtailed synthetic capacity comes to the fore in the attempt to incorporate the symptoms secondarily into the ego-organization. But often the reverse takes place. Then the ego is secondarily drawn into the sphere of conflicts, sometimes under the impact of a severe superego, and it is invested with drive-energy. The result is a paralysis of many of the ego functions including the harmonizing capacity, so that the ego can no longer mediate between the different demands from id, superego, and environment.

III. Character Formation

In the introduction I recalled the fact that psycho-analytic theory has developed out of the study of ailments with our neurotic patients. Though character formation is a 'normal' process in itself, I will keep to the line of including the influence of psychic disorders in our study of the development of character. I

have already mentioned the reaction formation leading to a compulsive character that shows distortions of 'normal' character traits. This is obvious in the case of exaggerated cleanliness, orderliness, and economy (the so-called 'triad of compulsion neurosis'). Earlier, Freud described these qualities as reactions against anal drives which in 'normal' development are methods of adaptation to the educational demands of the environment. They are called anal character traits. Similar processes find a place in connexion with oral and urethral impulses. Outcomes of them are seen in certain qualities of well-adjusted individuals, e.g. in eloquence, based upon oral tendencies, in productive ambition, developing out of urethral strivings, etc. In neurotic patients in whom the ego has failed to solve the anxiety-provoking conflicts in a harmonious way, the qualities become over-emphasized and rigid with more or less damage to other ego-functions, including autonomous ones. There are, however, other factors to be examined. Since we see 'character' as the 'usual (habitual) way in which a person deals with the inner and the outer world' (Fenichel, 1945) it is clear that it comprises more than the ego's reactions to id-impulses alone; we have to consider the vicissitudes of the development of the ego-organization as well. In the 'sphere free of conflict' the ego's autonomous functions come into existence. To begin with, the *inborn* potentialities out of which the ego will develop, determine to a great extent the outcome of the process of growth. The amount of intelligence, of capacities of perception, reality testing, thought-processes, etc., and last but not least the power of neutralization and sublimation, are decisive factors. If one or more of these natural abilities is lacking (or too feeble), the evenness of ego-growth will be disturbed and the integrative process is likely to be interfered with, though the synthetic function itself may be normal. But even with a favourable innate disposition opportunities may arise for a mal-development of the ego from the very beginning of life. The disturbances may come from within as well as from without. I have mentioned the influence of an unfavourable drive-disposition upon the coming into existence of mental disturbances. Especially a disproportion between sexual and aggressive drives is apt to disturb the course of maturation of the id as well as of ego functions, even in the first years of life, in the pregenital stages. Furthermore, the environmental influence is very important, because the

ego, like the id, develops in interplay of the mother's mind upon the infant's mind.

Again we start by looking at pathological phenomena. The 'simple' (transference) neuroses originate mainly in the oedipal phase in connexion with uncontrollable castration anxiety. The origins of the more severe disturbances, such as borderline cases, psychoses, delinquency, and even so-called character distortions, are to be found in the pre-oedipal phase, and particularly in an early arrest of ego-development. When a motherly object is not available, or when the mother herself is very disturbed, the conditions for a healthy development of ego-functions in the infant are lacking. The autonomous functions and the learning processes through imitation and identification are in need of an example as well as of stimulation by love, support, and understanding. The mother's love is equally (or even more) indispensable for the infant's learning to cope with id-impulses. Too much frustration hampers the ego's growth, resulting in an arrest on primitive levels and an inadequate manipulation of the requirements of the drives. In entering upon the oedipal situation the ego-functions are poorly organized, with the consequence that the strong demand for a solution of the Oedipus complex and for mastering anxiety leads to an incomplete solution and sometimes to a total disintegration. When, for example, an arrest took place in the phase where the body-schema began to be developed (that is, in the phase where the infant perceives his own body as a whole, as different from external entities) the function of distinguishing between self and outer world cannot be formed adequately. In schizophrenic patients we often observe representations of parts of their own bodies as being separate from other parts, as well as a fusion of the boundaries between the self and the object-world. In other words, there is a kernel of confusion between self-representations and object-representations, and the need to be 'one' with the mother cannot be adequately dealt with. A mother, who, clinging to the child, is unable to let him develop his own personality, will promote the arrest of the child's ego-development at this point (Sandler, 1962). A very disturbed mother, confused, egocentric, distracted, or rapidly changing from love to hate, does not provide the child with a stable image to incorporate. As a consequence, the development of delineated object-representations will be defective. The confusion between self and object influences the function of reality-testing. A

number of other ego-functions may be drawn into this pathological process as well. The development of motor-actions is dependent upon bodily sensations, including passively experienced movements. A disturbed, unloving mother is unable to hold and to carry around her baby with loving attention (see Winnicott's 'holding position' (1960)). This can lead to a lack of satisfaction in the motor sphere, resulting in a poor development of motility in the child.

The lack of a suitable object with which to identify impairs the development of ego-activities that have to be learned, such as speech, grasping, walking. In the emotional sphere the child is in need of a loving mother in order to advance from a need-satisfying object-relationship towards object-constancy. In order to deal adequately with id-impulses the ego has to be equipped with a sound self-esteem which can only develop normally if there is a firm object-tie.

The lack of a satisfactory love-relationship may lead to an arrest of ego-ideal development in the magical sphere, where the fantasies of grandeur and omnipotence have to compensate for the various frustrations. In some cases the advance from magical-wishful thinking towards realistic logical thinking is never adequately made. When a child with a similar early disturbance of development enters the phallic phase, his ego will certainly be unable to find a more or less harmonious way of solving the many problems involved in the various vicissitudes of the Oedipus complex. The defective ego-organization is not able to master castration anxiety, and alongside the regression of the drives to pre-genital stages the arrested ego functions will overaccentuate the archaic, untimely modes of behaviour.

I have already pointed to the differences in the genesis of the classical (transference) neuroses on the one hand and the manifestations of borderline and psychotic disorders on the other (see also Lampl-de Groot, 1962). In the first ailments the process of organization of ego functions has proceeded in an approximately 'normal' way until the oedipal situation. The regressive ego-phenomena emerged as a *consequence* of the regression of drives and in connexion with the defensive processes provoked by this instinctual regression. In the second conditions, the process of organization of ego functions never reached the level normally belonging to the phallic phase. The ego-defects are therefore of a primary nature.

What, now, is the impact of early arrests in ego-development upon the formation of a person's character? Our former definition of character as the habitual way of dealing with the inside and the outside world can be reformulated in view of recent ego psychology as follows: Character is the habitual way in which integration is achieved; this means: in which a person's ego solves conflicts with the internal world (id and superego), conflicts with the environment, and conflicts within its own organization (between its various functions and capacities).

It is clear that an unevenness in the development of the organizational process, an arrest of some functions and a 'normal' course for others, must give rise to conflicts within the ego-organization which cannot be solved in a harmonious way. In addition, therefore, to the pathological reaction to needs and instinctual tendencies, to superego and environmental demands, borderline and psychotic patients will show an ever-growing inconsistency in their ego-organization, leading to irreversible splits within their ego. The result may be a chaotic ego in which no synthesis is achieved. As a consequence the development of a 'habitual way of reacting' is impeded, and stable character traits cannot come into existence. If we still wish to speak of the 'character' of these patients, we can designate it only as an unpredictable mode of behaviour. A further complication is due to the poor, unequal development of the ego-ideal which stops, at least partly, at the stage of unrealistic omnipotent fantasies, provoking magical behaviour. In connexion with the unstable object-relations, the internalization of parental demands gives rise to precarious contents in the superego. But as the 'free-floating' aggression that the immature ego was unable to master is incorporated into the superego, the latter can become very sadistic towards the self, with the remarkable outcome that one of the very few habitual reaction patterns in these patients is a rigid masochistic behaviour. Processes that will normally be accomplished by ego functions with the use of neutralized energy, are in the patients 'sexualized' and 'aggressivized', that is, invested with deneutralized drive energy. In summary, pathological character formation could be classified under two main headings:

(i) Neurotically diseased persons show distorted character traits in consequence of defensive processes in which counter-cathexis and reaction formations have produced rigid and irreversible behaviour patterns owing to a

secondary regression towards stages in ego development of a primitive nature.

(ii) Psychotic and borderline patients present a failure of character formation as a consequence of early arrests in ego maturation which could never be passed over and a primary defect in the organization of ego functions, ego-ideal, and superego contents.

I want to stress once more that this grouping under two headings is made for the purpose of presentation. In practice we meet with transitions between the various phenomena. Neurotics, for example, may show psychotic mechanisms; obsessional neurotic patients may reveal paranoid traits, delusional and projective processes, etc.; psychotics may start with neurotic disturbances, and they may continue to employ neurotic mechanisms alongside psychotic reactions, depending on the different stages of development the various functions may have reached.

Let us now turn to the question how we are to envisage the course of events that leads to the moulding of a 'healthy' character. So far I have placed the words 'normal' and 'healthy' in quotation marks. It is often said that normality and health are arbitrary concepts. This is certainly true in connexion with the moral judgement of a person's behaviour. In a given society or group of individuals a certain line of conduct can be evaluated as 'normal' or 'healthy', whereas in another community it may be judged very 'abnormal' and 'sick'. But from a scientific point of view we have, I think, to follow a different line. We speak of bodily health when the various organs of the body function in such a way that stimuli from inside as well as from outside can be assimilated and vital processes are not disturbed.

In psychology I think we should consider a person to be in psychic health when the different areas of the mind have reached a cooperation leading to optimum mental functioning. As the ego is the structured part of the mind that has the disposal of the capacities of action upon stimuli (needs) from the inside as well as upon stimuli (demands) from the environment, we have to look at the nature of the ego-organization, and especially at the disposition of its synthesizing capacity, in order to decide between mental health or sickness.

'Character', being the habitual way of dealing with inner and outer world, is a property of the ego. The indication 'habitual' implies some kind of constancy in a person's reaction patterns.

We know, however, that life is not a static condition. Life processes involve change and fluctuations. The maturational processes reach a certain equilibrium (steady state) in adulthood, but they never come to a complete stop. Learning continues throughout life. Conflicts with the environmental demands and between the different substructures within the personality belong to the ordinary life-processes. Therefore the ego-organization and its synthesizing capacity have to possess some flexible qualities. We have said already that both id and ego develop out of inborn potentialities. The organization of the various ego functions comes into being only gradually in interplay with the drives in their maturational stages and with the simultaneous object-relationships. Therefore character traits, though dependent upon innate qualities, are largely the outcomes of adaptation processes. They represent the various adaptation mechanisms, among them reaction formations against id-impulses. In addition, character formation develops in interaction with the objects, through imitation and identification. (I want to stress the fact that the concept of 'adaptation' includes a change of the environment whenever such an influence is appropriate and within the person's power.)

As the adaptational processes are in need of a certain amount of constancy in order to function well, we again come upon the fact that a harmonious development requires both constancy and mobility. In what way is this seemingly contradictory state of affairs to be achieved? We may compare the state of mind with the oscillation of a pendulum. The central point is to be found in the nature of the ego's synthesizing capacity. Its constancy is to be found in the well-known automatisms based upon innate factors, and developed during growth. When conflicts (from within or from without) arise, the ego is alarmed by signal anxiety and an integrating action is initiated. If a harmony or adaptation cannot be achieved, some defensive actions are provoked; regression, for example, can take place. But when it remains 'regression in the service of the ego' it will only be temporary. If the ego has at its disposal enough knowledge of the factors involved in the conflict (of demands from the id, from the environment, and from the superego as well as from the ego-ideal), and if it has the power to master the different demands, the pendulum will swing from the one side (regression) back to the central point. Maybe it will temporarily swing to the other side

(a defensive compensation), but in the course of time the central point will again be reached. This means that a new equilibrium is achieved. Of course this description applies to an 'ideal' concept of a 'healthy' character. In practice this ideal will seldom be found. But slight deviations do not impair the person's performances and his well-being, and seem not to be appreciable. However, an arrest in the pendulum on the one side or the other will cause disturbances of the integrative process, the mobility having been abolished. Instead of describing more reactions and mechanisms subject to oscillations, I will now summarize as follows: it is a question of quantity (intensity) and of reversibility that decides whether a healthy or a pathological character development will take place. In other words, it evidently depends upon the intensity and the nature of the energy involved.

As the character develops in connexion with the simultaneous interplay of ego and id, and as mental energy stems, at least largely, from the drives, we have to examine once more the conflicts involved in this interplay. Intensity of energy employed in adaptation and defence is correlated with the intensity of the drive-demands in their maturational stage. Regarding the nature of the energy employed it is decisive whether enough neutralized energy is available for the ego to build up its autonomous functions and to adjust to inner and outer world. I think the process of neutralization is dependent upon an inborn nature of the drives, but at the same time also of an ego-quality. This is most clearly seen in sublimation, an adaptation mechanism *par excellence*. Sublimated activities are performed with the use of neutralized energy, but they can only come into being if the ego has specific talents and properties at its disposal. Logical, scientific thinking requires a special ego-ability; artistic performances come about only if the ego possesses enough of the necessary talent.

When an individual is gifted with a strong capacity to neutralize drive-energy and at the same time with great talents and ego-abilities, we may expect him to reach a high degree of integration. If often happens, however, that very talented people are subject to a rigid drive-constitution which does not allow for much neutralization. In these cases the development of the ego is impaired in spite of its original gifts, with the result that no synthesis is achieved. The talents and abilities originally present shrivel up. A reduced personality emerges with neurotic symptoms and/or neurotic, rigid character

traits. This is especially observable in cases with a lack of congruency between sexuality and aggression, that is with exceptionally strong aggressive drives. In the struggle against aggression, there cannot be enough energy neutralized, and the surplus of free aggression is internalized into the superego. The sadistically deformed superego demands self-punishment and more restriction of pleasurable activities. It counteracts the development of the person's talents and of many other ego capacities. The rigidity of the masochistic character is well known, and does not need further exposition.

On the other hand we often encounter a relatively poor ego-equipment, and here the main cause for a disturbed development lies in the ego's incapacity to deal with the id, even when the distribution of the drives is not an unequal one. A variety of outcomes is possible, and transitions from a slight unevenness in some ego-areas to total inhibitions of nearly every ego-activity are observed.

I want to point once more to the fact that the concept of 'health' does not cover the concept of 'valuable performances'. 'Health' designates a state of mobile equilibrium of the psychic apparatus. It is a scientific concept and not applicable in a system of values. An interesting example is genius. A man of genius is gifted with great talents, with a high ability to neutralize energy, and with a flexibility of mental mechanisms. But he reveals a strong tendency to conflict. Integration is achieved in the areas of his creative activities. In other areas of the personality, however, the conflict-solving synthesis may have failed. Here highly valued performances may go together with neurotic symptoms and/or character distortions.

As I cannot do justice to all the vicissitudes and outcomes of the various processes touched upon in this paper, I will present the following:

IV. Conclusions

- (i) Conflicts are normal manifestations in the processes of life.
- (ii) Conflicts stimulate development, whenever a person is able to solve them without damaging his integrity.
- (iii) The solution of conflicts is one of the activities of the ego-organization.
- (iv) The outcome of this solution depends upon a number of factors constituting the synthetic or harmonizing ability.
- (v) The nature of this integrative capacity is

decisive for a 'healthy' as well as for a pathological result.

(vi) The capacity to synthesize develops out of innate properties in connexion with the other ego functions, in interplay with the development of the instinctual drives, and influenced by object-relationships, by the environment at large, as well as by the nature of superego and ego-ideal. The connexion with object relations identification is of special importance for the development of ego faculties.

(vii) The properties of the instinctual drives, the distribution of libido and aggression, and especially the amount of possible neutralization (sublimation), have a strong bearing upon the final outcome of ego and personality development.

(viii) Equally important for a harmonious growth is the ego's capacity to make use of neutralized energy in developing qualities in the conflict-free sphere and to undertake sublimated activities.

(ix) Pathology emerges when the integrative

process fails; neurotic symptoms are formed when the ego, in conflict with the id, cannot synthesize id-impulses, demands of superego and environment, without the pathological use of defence.

(x) Character traits are formed as precipitates of mental processes. They originate in innate properties; they come into existence in the mutual interplay of ego, id, superego, and ego-ideal, under the influence of object-relations and environment.

(xi) 'Healthy' character traits allow the ego's synthesizing capacity to oscillate around a central point representing, the character-constancy. The oscillations express the mobility of the character and permit of change and reversibility.

(xii) 'Pathological' character traits are exaggerations and distortions of a 'normal' character; they are rigid and irreversible, and may lead to a hardening of the ego-organization and its various functions.

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CONFLICT, REGRESSION, AND SYMPTOM FORMATION¹

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The purpose of this communication is to consider certain problems of character and symptom formation from the point of view of recent developments in psycho-analytic theory. These developments have evolved from the structural hypothesis and from the new theory of anxiety, the 'signal' theory.

The modern frame of reference of psycho-analytic theory accords special significance to the role of intrapsychic conflict. It is based upon the interplay of opposing tendencies in the mind. These tendencies represent characteristic and consistent mental trends which can be grouped together according to their specific functions. In fact, in this hypothesis the agencies of the mind are defined by the functions assigned to them. The consistent, repetitive, organized, usually predictable mode of behaviour which qualifies these agencies of the mind enables us to consider the ego, the id, and the superego as 'mental structures'. This, of course, is structure only in a functional sense. When the interplay of opposing forces is harmoniously integrated (by the ego), it is most difficult, if not impossible, to demarcate the limits of the component structures of the mind (A. Freud, 1936). Situations characterized by intense intrapsychic conflict, on the other hand, reveal with greater clarity the differentiation among ego, id, and superego. Certain pathological clinical entities serve to dramatize more sharply the functional separation of the id from the ego and the superego, e.g. hysteria; others, like depression, may illustrate the functional schism between ego and superego. It was, in fact, the meticulous scrutiny of this type of clinical data which led Freud (1923) to revise his theory of mental function in favour of the structural hypothesis.

While the statements in the preceding paragraph are fundamental, they are also oversimplifications. The genetic approach, which is one of the most characteristic features of psycho-analysis, emphasizes another basic principle: the

continuity of psychic experience. Each phase of mental development is influenced by what has taken place earlier in the experience of the individual and in the development of the mental apparatus. Intrapsychic conflict may become a sterile and empty concept if one does not take into account the peculiar, idiosyncratic features of the component psychic structures which participate in the intrapsychic conflicts. The shaping of psychic structure, according to Hartmann, Kris and Loewenstein (1946) may be studied to best advantage by assessing the relative contribution of maturational versus developmental factors, that is by studying the interaction between inborn, biologically-determined endowments on the one hand and the special experiences of the individual on the other.

In the past, greatest stress fell upon the role of frustration of the instinctual drives as the spur to mental development. This was applied to mental development in general and to symptom and character formation in particular. The vicissitudes of drive gratification, the pleasure-unpleasure continuum, remain of course factors of major significance; but the idea of a simple relationship between frustration and development or between repression and symptom formation has been modified considerably in recent years. From the work of many analysts it appears, for example, that intense frustration of the drives during the first few months of life may have a most deleterious effect upon the development of some of the essential functions of the ego. Frustrations during later periods of life, on the other hand, may have a most stimulating effect. In other words, the same quality of experience may evoke different effects at different stages of development. This was demonstrated very strikingly, for example, by Coleman, Kris, and Provence (1953) in connexion with the difference in the attitudes of the same parents towards the expressions of instinctual drives in

¹ This paper, together with Dr Lampl-de Groot's paper in this issue, will be the subject of a discussion at the 23rd International Congress of Psycho-Analysis, Stockholm, July-August, 1963.

their children at different phases in the parents' lives. This is only one example of how analysts have become aware of the complex interplay between the vicissitudes of the drives and the frustrating or gratifying environment. Variation in parental attitudes is only one of a great number of possible influences which may help determine not only the patterns of drive discharge but also the predisposition to conflict and the choice of defensive measures to abate the conflict.

Considerations such as those mentioned above have shifted the attention of analysts to new areas of study. These studies emphasize the developmental forces which mould the patterns of drive discharge, which give special form to the functions of the ego and subsequently to those of the superego. Such studies have altered to a considerable degree the context in which we view character and symptom formation. Since the ego is the executive agency of the psychic apparatus, it is its activity and mode of behaviour which determine the issue of mental health or illness, normal or pathological adaptation, inhibitions, symptoms, character traits, or sublimation. In any instance, the resultant phenomenon reflects how the ego has integrated the conflicting demands of the id, superego, reality, and its own interests. But there are many forms and different levels of integration, many of which from the point of view of the ego may be regarded as unsuccessful. In some instances the ego may have had to surrender control over some of its functions (e.g. as in symptoms) or to limit drastically certain goals or sources of pleasure (e.g. inhibitions); or the ego may be burdened by a constant strain upon its resources, restricting its capacity to develop other interests and activities.

What elements determine the ego's efficiency and adaptability? What factors of experience with the environment and within the individual's mind influence the quality and the strength of the integrative resources available to the ego? A large portion of the psycho-analytic literature of recent years has been devoted to answering some aspect or other of these questions. Interest in such subjects as the development of object relations; the predisposition to anxiety; the maturation of the danger signal; the selective preference of the ego for certain mechanisms of defence; the precursors of the superego; regression of ego and id functions; is typical of this trend. This list constitutes only a small segment of the range of topics related to this problem, and all of these bear directly on the subject of

this symposium, 'Character and Symptom Formation'.

It would be impossible to deal effectively with all these problems even in an extensive series of publications. The situation is rendered even more difficult by the fact that many analysts are still not at home in this frame of reference. There is a tendency, as Hartmann (1946) has observed, to carry over into the new set of theories, concepts and hypotheses which were devised for an earlier frame of reference. These concepts and hypotheses are not entirely consistent with the new approach. This combining of hypotheses has resulted in certain misconceptions concerning the genesis and significance of symptoms and character traits. It has also contributed, I believe, to obscuring essential features of the methodology of psycho-analysis.

What I propose is to explore three areas of psycho-analytic work in order to demonstrate how the considerations just mentioned touch upon some questions of character and symptom formation. While these three topics have been separated for purposes of discussion, in actual experience they cannot be considered in isolation. The topics are:

- (1) The nature of the 'danger' situation.
- (2) Regression and pre-oedipal influences.
- (3) The function of fantasy.

I. The Nature of the 'Danger' Situation

Current psycho-analytic concepts of symptom formation date to Freud's *Inhibition, Symptoms, and Anxiety* (1926). The formulations which he advanced in that essay place the warding off of danger by the ego as the central point in symptom formation. Anxiety is the signal which alerts the ego to the imminence of some internal 'danger', i.e. the emergence of derivatives of a previously repudiated instinctual drive. The specific features of a symptom are determined by the way in which the ego tries to avoid the danger and the concomitant, unpleasant anxiety which accompanies such situations. In Freud's earlier theories (1912), frustration was the essential factor in symptom formation. The process of symptom formation, it was felt, was initiated by some quantitative accumulation of instinctual drive energy which in the face of inner or outer obstacles could not find discharge. The characteristic precipitating factor was either the rupture of some libidinal relationship or some physiologically determined increase of libidinal influx. In either case, the result was the same. The ego had a new task. It was charged with mastering

an intensified libidinal demand. The problem of the ego, of its character and resources, was entirely secondary to the economies of libidinal demands.

In *Inhibition, Symptoms, and Anxiety* (1926) Freud went to great lengths to define the nature of symptoms. The term symptom, he said, should be reserved for the result of the failure of defence against the derivative of an instinctual drive. The drive, in the symptom, had forced its way to satisfaction in spite of the determination and the efforts of the ego to prevent this. The resulting symptom, however, is a distorted and substitutive gratification. It has combined into its structure the ego's efforts to integrate the opposing claims of the id and reality as well. It follows in its composition, as Waelder pointed out later, the principle of multiple function (1936).

To recapitulate, what stimulates the ego in its determination to bar expression to derivatives of the instinctual drives is the fact that these derivatives are interpreted as potential dangers. The anxiety signal, an unpleasant affect, stimulates the ego to institute various defensive manoeuvres. The developmental implications of these statements deserve special attention. A certain minimal degree of organization of the mind, of psychic structuralization, must be attained before so complex an interrelationship of functions is possible. The ego must have developed sufficiently to be able to assess and interpret those sensory impressions which are understood to indicate danger. In addition, the function of defence must have developed beyond the stage of primitive denial and projection. Even the anxiety signal itself, which is based on an inherited, biologically determined response, must pass through a certain degree of maturation and development before it can be used effectively by the ego for the purpose of activating the mechanisms of defence (Brenner, 1953; Schur, 1953; Rangell, 1955).

What is the nature of the danger to which the ego responds with anxiety? From his clinical data Freud (1926), found it useful to demarcate several broad categories of danger situations. He described a hierarchy of danger situations, an ontogenetic sequence of situations of danger which were typical for the successive phases of psychosexual development. The first in the series of such situations is the danger of the loss of the object. This is connected with the earliest tie to the mother or mother substitutes. In the more recent literature it has become the proto-

typical situation from which the varieties of separation anxiety have been derived. The danger situations which follow in turn are the fear of the loss of the love of the object and the fear of punishment. Fear of punishment is closely linked with the idea of retaliation, usually in the form of bodily mutilation and classically associated to the Oedipus phase of development. After the resolution of the Oedipus complex and with the establishment of the superego, fear of conscience becomes possible. To what extent this last fear actually plays a role in symptom formation has never been thoroughly explored. The most important source of anxiety in the psychoneuroses stems from the fear of castration, just as the most common point of fixation and regression is to the phantasies and wishes of the Oedipus phase.

This rather long description of the typical danger situations in the structure of symptoms has been introduced because in the literature of recent years the nature of what constitutes danger to the ego, of what sets in motion the process of defence, has become increasingly obscure. Despite the definition of a symptom as a compromise between an instinctual drive which forces its way to substitutive gratification against the efforts of the ego (to contain it) one encounters formulations which blur the role of conflict among the various agencies of the psyche. These formulations do so by removing the specific danger from the realm of the instinctual drives and their derivatives. A brief enumeration of some of the more common misconceptions follows. Symptoms have been described as representing defence against affects or as responses to the threat of loss of ego boundaries or loss of identity. On occasion one reads of symptoms serving to fend off the danger of regression or the loss of reality or of loss of ego functions in general. Other symptoms have been analysed as a reaction to conflicting identifications, i.e. an intrasystemic conflict, a conflict within the ego. On the other hand, some symptoms have been said to result from a conflict between opposing instinctual drives—i.e. a conflict within the id.

Formulations such as these illustrate the correctness of Hartmann's observation that many aspects of the structural hypothesis have not been fully assimilated into psycho-analytic conceptualizations. In symptom formation, the pathogenic conflict takes place among the different systems of the mind. The immediate impetus to the mobilization of defence on the

part of the ego is the need to ward off the anxiety associated with the threatened emergence of a forbidden instinctual wish. Much of the activity of the ego in such a situation is carried out at an unconscious level. This applies with equal force to the task of recognizing the evolving danger situation. The entire situation is at one level of mental life, expressed in the form of some phantasy, conscious or unconscious, which like a dream can be translated into a verbal statement (cf. Lewin, 1952). The phantasy is more than a vehicle for an emerging instinctual wish of the id. Phantasies, like symptoms and dreams, demonstrate the effects of the integrative function of the ego. In phantasy formation the ego tries to reconcile the demands of all its subordinate relationships—the id, the superego, and reality (Eidelberg, 1945). This means that in the phantasy the expression of danger is given concrete form. The nature of the phantasy reveals not only the level of the instinctual wish which it conveys, it reflects the level of ego functioning at the time of the original conflict. In the formation of a phantasy the ego attempts to integrate the conflicting demands of all the agencies of the mind, and it does so in terms of the immature state of its functions and of the superego function, of the domination by primary process tendencies and the inadequate grasp of reality and causal relationships prevalent at the time. The expression of danger in the phantasy is based upon earlier sensory imagery or experience. The meaning of these statements will become clearer perhaps in the critique of some of the formulations mentioned earlier, and it is to this critique that we now shall turn.

Some of the misconceptions referred to concerning symptom formation may result from an attempt to use inaccurate shorthand expressions for more complicated phenomena. In other instances the effects of the ego's defensive efforts against the danger may have been mistaken for the danger itself. For example, impairment of the sense of reality in such experiences as *déjà vu*, depersonalization, and derealization result from the ego's attempt to ward off anxiety. That anxiety or other unpleasant affects accompany such symptoms is a token of the fact that the ego's efforts have been successful only to a limited degree. In such symptoms the relationship between the symptom and the unpleasant affect is analogous to the affect in the typical dreams of missing trains or taking examinations. The patient feels unreal because he is anxiously

warding off some danger. He does not feel anxious because he is having feelings of unreality (Arlow, 1959). To accept the patient's rationalizations as explanation of the structure of the symptom is comparable to interpreting the meaning of a dream from its manifest content.

To turn to some of the specific formulations. Some symptoms have been described as defences against the emergence of dangerous affects. In actual practice this type of danger situation may have many different meanings, i.e. the danger has to be inferred from the contents of the experience, from the knowledge of which childhood constellation of events is being recapitulated in the symptom. For example, giving vent to powerful affects may unconsciously represent losing control of the urinary or anal sphincter, i.e. the discharge of some erotic and/or aggressive wish. The danger may arise from the fear of punishment by the parent or loss of the parent's love. Furthermore, losing control of affective expression may signalize a wish for uninhibited aggression, provoking the danger of destroying the love object or of retaliation at the hands of the victim of the aggression. In a concrete form, losing control of affects may symbolically come to represent losing bowel contents with all the significance which can be attached to the fecal mass. In other words, the manifest fear of which the patient complains should not be confused with the unconsciously conceived danger.

In recent years there has been much interest in problems of identity and identification. In this connexion, symptoms have been described as representing part of a struggle against identification or as an outgrowth of the struggle between opposing identifications. An identification *per se*, however, does not pose any danger to the ego unless it is effected in pursuit of some forbidden impulse. The danger arises not from the identification but from the drive gratification which such identification signifies. Again, the identification is one element of a phantasy which serves in part as the medium or expression of an instinctual wish. A typical example may be cited from the experience of a woman patient who in childhood had been witness to the primal scene. Subsequently, she identified herself with the mother in phantasy. Her conflict arose, however, from her tendency to view the act of intercourse in a masochistically distorted fashion and to regard her mother in the original experience as the victim of a brutal assault. The danger to

which the ego responded was the threatened emergence of the masochistic wish. The identification in question was only one event in the elaboration of this patient's masochistic drives.

A conflict between opposing identifications, it may be argued, actually represents a conflict between opposing drives. In such instances, Freud (1917) pointed out, the ego is aligned with one side of the conflict. Where there appears to be a conflict between opposing drives, the ego takes sides with the expression of one set of drives, i.e. permits the discharge of the cathexis of one drive, in order to fend off expression of the other, the more objectionable drive representation. Conflicts of this type which are described as taking place exclusively within the id, in actuality represent a conflict between the ego and the id, with the superego apparently in accord with the defensive position undertaken by the ego. For this reason, Brenner (1951) observed that when a drive is used as a defence, what usually results is a perversion or a character trait rather than a symptom.

The disintegrative effect upon the ego of overwhelming anxiety is well documented from the experience with borderline and psychotic patients. The interplay of forces here is the same as in neurotic symptom formation except for the importance of pre-phallic drives, aggression, and the ease with which ego functions, ordinarily outside the realm of conflict, are brought into the nexus of conflict and are reinstitualized or regressively altered during the defensive struggle. In many borderline and neurotic patients, symptoms characterized by severe, but transient, alterations of ego function (e.g. reality testing, sense of time, and identity) may be traced to defence against typical castration anxiety when one is able to translate the conscious psychological experience in terms of the ego's response to the unconscious phantasy.

Annie Reich (1960) has made similar observations concerning the danger of narcissistic mortification. According to earlier authors (e.g. Fenichel, 1945), the danger of narcissistic mortification was equivalent to the danger of losing the object. This equivalence was based on the following line of reasoning. The phase of primary narcissism coincides with the earliest months of life. The typical danger during this period is the loss of the love object, concretely experienced as the danger of losing the breast or the sustenance from the breast. Supplies of narcissistic gratification, therefore, were made

identical with supplies of milk. The danger of narcissistic mortification signified the threat of being without mother's milk. Later observations concerning the development of object relations and the evolution of the superego and ego-ideal (Jacobson, 1954) made possible a more penetrating understanding of the problem of narcissistic vulnerability. In many instances, the defence against anxieties typical for later phases of development, e.g. castration anxiety, may be expressed as defence against narcissistic mortification. The connecting link, according to Reich, can be traced to the comparison between the actual self as measured against a pathologically aggrandized, instinctualized ego ideal. The image of the ideal object is conceived as being narcissistically and omnipotently invulnerable. For many patients, only the realization of such an ideal of invulnerability may render them free from the fear of castration.

II. Regression and Pre-phallic Factors in Symptom Formation

Regression is an essential feature of almost all symptom formation in adults. Exceptions may be noted in those instances in which symptoms persist without interruption from childhood into adult life. More often, the effects of such prolonged, unresolved intra-psychic conflict are to be found in character traits rather than in symptom formation.

Regression is a ubiquitous tendency in mental life. It occurs at all stages of development, although it is, of course, more characteristic of the immature young psyche. In children, where the ego structure is still quite plastic and the defensive resources relatively undeveloped, traumatic events or conflicts usually eventuate in some form of regression rather than in the appearance of symptoms. The more recently acquired forms of ego mastery are among the first to be surrendered (A. Freud, 1951).

In adults, as in children, regression may involve not only the functions of the id; it also involves the functioning of the ego and superego. Ordinarily most regressions are transient and reversible. The regressions which concern symptom formation are persistent and involve derivatives of the instinctual drives. Symptoms are formed on the basis of a conflict over some regressive reactivated instinctual wish from childhood. Without conflict over the regressively reactivated wish, no symptoms appear. Simple regressions, which meet no opposition from the ego, can and do occur. They may take the form

of pathological or perverse traits. However, when the ego is opposed to the expression of the regressively reactivated instinctual wishes and is unable to master or bar expression to their derivatives, symptoms are formed.

According to Freud (1912) the process may be initiated in several ways. In the classic model of symptom formation, Freud emphasized the initial phase of introversion. Faced by some externally or internally determined libidinal frustration, the individual turns from gratification in reality and attempts to achieve, instead, gratification in phantasy. The analysis of symptoms regularly demonstrates that the wish of the phantasy is a regressive one, i.e. it represents the reactivation of a wish phantasy from childhood, one which in most instances had its origin during the Oedipus phase. This reactivated wish becomes the focus of conflict in symptom formation.

Later, after he had introduced the structural hypothesis, Freud (1938) demonstrated the existence of what is perhaps a more common mode of onset of neurotic symptoms. A neurotic illness may be precipitated when the individual finds himself in a realistic situation which corresponds to some earlier traumatic experience. The new experience contains within it elements which may be interpreted as a fresh repetition of the original conflict. For example, a young woman secretly in love with her employer developed agoraphobia when she discovered that he was engaged to be married. She also suffered from intense claustrophobia in certain shops. This symptom could be traced to her anxiety over an impulse to steal. Both the agoraphobia and the anxiety over the temptation to steal, upon analysis, prove to have been derived from a phantasy of forcibly seizing and stealing the phallus. This phantasy had its origin during the sixth year of the patient's life, shortly after the death of her father. She had responded to his death with intense feelings of disappointment, thinking that now that he was gone she could never realize her expectation of getting the phallus-child from him. She accordingly would have to take independent and violent action on her own. The engagement of the employer was more than the rupture of a libidinal tie. It

constituted a confirmation by reality of her earlier disappointment in phantasy. The employer, now lost to her forever, was bestowing his phallus upon some rival. This situation not only reactivated her furious determination to get what she wanted, it also weakened the opposition of the superego to such a wish, inasmuch as the patient felt righteously aggrieved. The superego was 'corrupted by injustice' (Alexander, 1930). As a result of this realignment of forces, the ego was no longer as effective as it had been previously in staving off expressions of this patient's aggressive, castrative, id impulses.²

External, realistic experiences may serve to precipitate symptoms or neurotic character traits in other ways than by recapitulating an earlier traumatic event. It is sometimes sufficient if the realistic situation conforms in its structure to the essential features of the unconscious phantasy, or if the realistic situation is so constructed as to facilitate the foisting or the projecting upon it of the elements of the persistent unconscious phantasy. Up to a certain point in her life, for example, a woman with unconscious masochistic trends was able to keep her masochistic wishes under effective mastery by the ego. Reassurance on the part of a friendly and interested authority figure was a useful and reliable element in her system of defences. With a new employer who was somewhat detached or objective, the patient became anxious and upset. A routine request for some work was enough to set off an outburst of tears or brooding. The patient ascribed her reaction to the fact that her employer had a cold and unfriendly look in his eyes, but she realized that this explanation was not adequate. Her behaviour was not justified by reality. Actually the patient's behaviour was in conformity with an unconscious phantasy of being beaten, or resisting rape. A slight shift in the composition of the external environment, a new employer, facilitated the possibility of projecting the elements of the phantasy from the past upon her realistic situation in the present.

The regressively reactivated instinctual wishes which stimulate the conflicts in psychoneurotic symptom formation usually originate during the Oedipus phase. This can be determined from the

² This material illustrates the reciprocal relationship between the persistent unconscious phantasies of the id (which is another way of expressing fixation) and the events of the individual's life. The persistent phantasy serves to maintain a constant 'set' which colours the interpretation and the significance of external events. External events on the other hand provoke, stimulate,

and organize the re-emergence of repressed instinctual wishes. The returning of these repressed instinctual elements may achieve temporary discharge in dreams and parapraxes. In fact the regular dreaming of non-neurotic individuals demonstrates the universal persistence of such phantasy wishes and their regular stimulation by the events of the day.

analysis of the unconscious phantasy upon which the symptom is based. The origin of the phantasy must be traced back to a specific time and set of circumstances in the individual's life. It is neither accurate nor methodologically sound to describe the level of regression according to the manifest representation of the drive contained in the symptom. There persists nevertheless a mistaken conception that the specific instinctual drive manifestations represent evidence of regression to or fixation at the level of development when the particular drive was dominant. Thus, in the analysis of a symptom or a phantasy, it is assumed that an oral wish, all oral wishes, of necessity, have their origin during the first few months of life, during the so-called 'oral' phase.

The tendency in psycho-analysis, to designate the early phases of development according to the particular drive which is dominant at the time, has certain disadvantages. To begin with, the concept was based on the study of the libido alone. Data relating to the elaboration of the aggressive drives and to the development and maturation of the ego are not sufficiently represented in this formulation. In addition, I feel that this tendency has contributed to a misunderstanding of the phenomena concerning drive regression. As Freud (1905) emphasized, infantile sexuality is characterized by many loosely organized, individual drive components. Only later in life are these separate trends fused in relation to the primacy of the genital impulses. While certain manifestations of the drives are dominant during certain periods, they remain persistent throughout life, and other drive components may be recognized even prior to the period when they attain ascendancy. For example, important manifestations of the phallic drives may be discerned before the phallic phase (Loewenstein, 1950).

In addition there are different kinds of wishes associated with any particular component drive, whether oral, anal, or phallic. The drives also undergo transformation *vis-à-vis* the developing ego. Some explanation of these two points is in order. Let us take, for example, manifestations

^a Similar considerations apply to derivatives of the aggressive drives, although the levels of organization of the manifestations of aggression have not been as clearly defined as in the case of libido. Hartmann, Kris and Loewenstein (1949) have suggested that a series of maturational phases, parallel to those which pertain to the organization of the libidinal drives, would be a useful context in which to study the development of aggression. In assessing the role of aggression in symptom formation Schur (1960) has called attention to the need to consider

of the oral drives. In the very beginning of life, representations of oral wishes take place at a very primitive level of sensory impressions, of states of tension and unpleasure and with only the beginning differentiation of the self from the transitional objects and the object world. The pursuit of a tension-free state of satiated bliss accompanied by a loss of the object world, by a sense of fusion of self with object, has been described by Lewin (1950) as the proper conceptualization of the type of instinctual representation which characterizes regression to this level as observed in certain mental illnesses. Quite a different type of oral drive representation may be observed after the phase of constant object relations has been established. In this later context fear of starvation and separation anxiety constitute the specific dangers. The id impulse is not for fusion and blissful oblivion but for dependent oral gratification from a well-conceptualized object. This type of oral wish most likely stems from the so-called 'anal' phase of psychosexual development, inasmuch as most observers are of the opinion that stable, constant object relationships are not established until the beginning of the second year. Finally there are those oral drive manifestations which are used to express wishes characteristic of the Oedipus phase. For example, a young boy during the oedipal period gorged himself on marble cake. He explained his behaviour by saying 'I'm eating a lot of marble cake. I'm going to become Captain Marvel'. He was acting out the classical cannibalistic phantasy of incorporating the father, his phallus, and his magical prowess. Such a phantasy may lead in later life to various oral symptoms, e.g. globus hystericus, anorexia, etc. The level of regression in such symptoms would not be to the 'oral phase'. It would be a typical regression to an oral phantasy which originated during the phallic (oedipal) phase. Cannibalistic phantasies do not necessarily signify a regression to or a recapitulation of the conflict or events of the oral phase.^a

The effect of misunderstanding the concept of regression and of the tendency to treat all derivatives of the drives as if they originated

the level of regression and the precise stage of organization of aggressive drive. Aggression becomes a source of danger only after a certain degree of maturation of the psychic apparatus has taken place. Diffuse physiological tensions related to aggression have to reach the point of drive organization where aggression is experienced as hatred. At this point, according to Schur, circumscribed defences can be formed, the danger situation can be appreciated, and symptom formation against derivatives of the aggressive drives becomes possible.

during the developmental phase in which the particular component drive was dominant, has been to push further and further back into the life history of the individual the origin of the phantasy and conflicts which determine symptom formation. This line of reasoning leads to a concept of infinite regress. It leads to the impression that the essential experiences which shape character and which influence symptom formation occur in the first few months of life and that later events are secondary. When the period of the pathogenic conflict is extended into the earliest phases of mental life it becomes most difficult in clinical practice to define the precise mental content of the wish or of the danger situation. Recollection is almost impossible and reconstruction has to be based on preconceived concepts or by resort to physiological models. This tendency may be illustrated from some observations concerning hysteria and phobia. Classically these clinical entities have been traced to conflicts over wishes originating during the Oedipus phase. According to at least one observer, however (Greenson, 1959), phobic symptoms have a much earlier determination, i.e. from the earliest phase of primal anxiety. Phobic symptoms are regarded as 'displacements from the original conflicts and the traumatic anxiety state itself is linked to the terrifying helplessness of the primary infantile anxiety reactions. . . . In successful treatment one eventually arrives at a revival of the original primary anxiety states of childhood and infancy.' Such a formulation brushes aside, or at best places in a secondary role, the specific mental content of the danger situation to which the ego responds with anxiety. Kohut (1959) has dealt extensively with the methodological errors which apply to conceptualizations which attempt to view various traits or states of experience in adults as reversions to a primal psychological gestalt which cannot be reduced further by analysis. Extreme anxiety reactions may indeed represent regressions to some childhood phase of experience, but not necessarily to a 'normal' phase of anxiety. The extreme anxiety reactions encountered in severe phobics constitute a regression to a phase of childhood pathology, a reversion to the period of the infantile neurosis. As stated earlier, this can best be ascertained by tracing back the phantasy of the neurotic symptom to the time of its origin in the history of the patient and by placing it within the framework of the immature ego organization which existed at that time.

It would be an error on the other hand to minimize the importance of preoedipal factors for the problem of neurogenesis. The events of this early stage exert a decisive influence on the structuring of the psyche. They have to be evaluated from the point of view of how they retard or advance the development of the structural elements of the psyche. A very extensive literature on this subject already exists. Since it would be impossible to attempt to cover this work, it will have to be sufficient to call attention to a few of the headings which bear upon symptom formation.

Preoedipal factors are of primary importance in the patterning of the drives and the defences. Greenacre (1952) emphasized the study of the preoedipal conditions which influence and distort the nature of the id. She cited observations indicating how the regular development of the libidinal phases may be interfered with by overstimulation of the young infant or by extreme frustration. Such experiences may leave their imprint upon the subsequent nature of genitality in particular and upon the capacity for pleasure. The vicissitudes of the preoedipal drives may also serve as models upon which the ego may pattern its mechanisms of defence—ego projection and introjection.

A great deal has been written on how object relations during this period influence not only the patterns of drive discharge, but also the emergence of stable identifications. These identifications may foster the evolution of certain modes of problem solving, the capacity for sublimation, and the selection of favoured mechanisms of defence. The precursors of the superego, or more precisely, the qualities which subsequently characterize the mode of operation of the superego, may be traced to the preoedipal patterns of drive discharge and to the preoedipal type of object relations and identifications. The identifications effected during the preoedipal phase, however, are not in themselves any more neurogenic than identifications effected at other times. As mentioned earlier, what is important from the point of view of symptom formation is the drive component which the identification represents and the failure of the ego to resolve the ensuing conflict. The Oedipus phase is crucial for symptom formation because by this time there has occurred a degree of crystallization of psychic structure which is necessary for intra-psychic conflict.

Let me cite a clinical example in order to illustrate how identification during the pre-

oedipal period and the vicissitudes of the pre-phallic drive determined the mechanism of defence employed by the ego in a case of depersonalization.

The patient was a 31-year-old housewife who came to treatment with many complaints. Outstanding among these were severe attacks of depersonalization and anxiety. Ordinarily she was a quiet, rather obsequious woman, but when she *heard herself*, as she described it, shouting at her children and *observed herself* losing control, she felt she needed help. During treatment it was discovered that the attacks of depersonalization occurred either in association with scenes of violence, when the patient experienced the surging of violent impulses, or when she was in a situation of overhearing or being overheard in private activity, especially activity connected with going to the bathroom.

The patient, an articulate woman, was able to give a very exact description of her subjective mental state during an attack of depersonalization. She said she felt as if she were suddenly split into two persons, one person who was experiencing and another person who was standing off at a distance observing her own self in action. She felt involved with the 'observing self' and dissociated from the 'experiencing self'. By this type of splitting during attacks of depersonalization the ego was able to repudiate to a degree the emergent id impulses which threatened to break through the barrier of repression. In effect, during an attack of depersonalization, the patient's unspoken defence could be expressed in the following words, 'I do not have to feel threatened or guilty. What is happening has nothing to do with me. I am only an observer.'

The conflicts from which the patient was suffering were the outgrowth of a disappointing marriage to a distant, cold, detached husband. She felt that the marriage had been a grievous mistake, but she could not get herself to do anything about it because she could not admit to her parents that she had 'made a mess' of her life. Instead she became anxious and withdrawn, unconsciously involved in phantasies related to her oedipal period. These phantasies centred on the wish to replace her mother in relation to her father and were connected with two experiences of witnessing the primal scene. She interpreted the primal scene experiences in a typical sado-masochistic fashion and reacted to them with mild depersonalization. By splitting into a participating and observing self she repudiated the masochistic and retaliatory dangers which might follow from her identifying with her mother in phantasy. The bathroom fears of overhearing and being overheard were actually anal representations of the oedipal wishes associated with the primal scene.

The tendency to render alien certain portions of her experience was soon well documented. Her true feelings about her husband were not voiced by the

patient herself. They became apparent from the analysis of a number of short stories which the patient had prepared for a class in creative writing. Even in this class, the patient did not behave as the other students did. She had to dissociate herself from her own product. Unlike the other students, she could not read her own creations. Someone else read her story for her while she behaved like any other observer in the class. She had severe social anxiety and she was afraid of criticism, especially if she lost control of her speech, her emotions, etc.

The danger of losing control reminded the patient of two prototypical situations involving the split of the ego into an observing and participating self. On the first day of kindergarten, the patient had an 'accident'. She lost control of her urine and made a puddle in the classroom. The unsympathetic teacher gave the patient a cloth and made her clean up the puddle while the rest of the class stood around jeering and laughing. At first the patient felt overwhelmingly humiliated, but she mastered the embarrassment by a split in her ego. Suddenly she felt that she was one of the group of her classmates, laughing and jeering at the unfortunate little girl in the centre of the circle, with whom the patient now felt no sense of identification at all. She had become the observer, and by repudiating the humiliated self, who was busy mopping up the urine, she no longer felt ashamed.

The model for this type of splitting and for repudiating a portion of the self had been established during the period of bowel training. The mother was a peculiar person whose life revolved around her own and her children's bowel habits. She foisted many of her own bathroom rituals upon the children, examined their stools, established regimens of mineral water, enemas, etc. She insisted upon cleanliness and control and would repudiate and humiliate any child who made a mess with the bowel movement. The patient developed a pattern of defiance against such treatment when in her rebellious defiance she had some 'accidents' and lost her stool. She learned to walk away from the stool and to come upon it a few moments later with a feeling of complete dissociation. The stool no longer had any connexion with herself. She completely repudiated her own product. What a few moments before had been within her own body and identified as part of her own self, had now become ego-alien and foreign.

This small fragment of the analysis demonstrates how the identification with the mother during the 'anal phase' and the vicissitudes of the anal drives shaped the experiencing of danger, the superego reproach, and the defensive activities of the ego in connexion with typical wishes of the oedipal phase (cf. Jacobson, 1959). Wangh (1959) has made a careful study of how the preoedipal experiences of a patient so moulded the psychic structure, especially the

ego defences and identifications, that the development of phobic symptoms was in effect an almost predictable outcome of the conflicts of the oedipal phase.

In a similar vein, Greenacre (1955), while noting that fetishism is specifically related to the castration anxiety of the Oedipus phase, nevertheless pointed out how the conflicts and developmental distortions of the preoedipal period influence and find ultimate representation in the structure of the fetishistic perversion.

III. *The Function of Phantasy*

The role of phantasy in symptom formation has been referred to repeatedly in earlier portions of this paper, so that only a few additional comments will be necessary at this point.

Freud (1908) very early appreciated the role of phantasy as an intermediate stage in dream formation, artistic creativity, and certain hysterical symptoms. At that time he thought of phantasy in terms of highly organized mental products readily accessible to consciousness. They belonged in the topographic hypothesis, to the system Pcs. Somewhat later, however (1915), he made special note of the fact that phantasy formations in normal and neurotic persons may be quite inaccessible to consciousness. They make their existence felt by the derivatives which they produce, i.e. by the pressure which they exert upon the ego for discharge. Thus, while such phantasies belong to the system Ucs as representatives of the unconscious instinctual impulses, at the same time by virtue of their high degree of organization, and their definite verbal concepts and object representations, they also partake of the characteristics of the system Pcs.

Phantasy is a type of mental functioning which takes place constantly and at various levels of consciousness. In a phantasy the wishes of the id are integrated by the ego with the other systems of the mind. There is a hierarchy of phantasy formations in the mind of each person. This hierarchy reflects the vicissitudes of individual experience as well as the influence of psychic differentiation and ego development. Phantasies are grouped around certain basic instinctual wishes. The same id impulse may be expressed in different types of phantasies depending on the maturity of the individual and the integrative and adaptive capacity of the ego. The phantasy expression of the id wish grows up, as it were, as the ego matures. The same wish may find expression in various phantasies of which some

are pathogenic, while others may occasion no conflict whatsoever. Each phantasy version of the id impulse corresponds to a different 'psychic moment' in the development of the individual (Arlow, 1961). The older, more mature phantasy expressions of unconscious wishes are integrated by the ego at a higher level and are more accessible to consciousness. The more primitive phantasy expressions are barred from consciousness or discharge by the defences of the ego. The more primitive phantasy expressions are more directly related to the danger situation. This is not so in the case of the more integrated expressions of the same id wish. Accordingly, in clinical practice it is most important to be able to uncover the precise way in which the unconscious instinctual wish is given form in the phantasy. It corresponds, for example, to the difference between the wish to impregnate the mother as expressed in a phantasy of entering her body, a wish which may eventuate in a phobia for tunnels, as opposed to a highly sublimated rescue phantasy which finds fulfilment outside the realm of conflict in the choice of a profession. In the tunnel phobia, for example, the phantasy may continue to the point where there is an encounter with the oedipal father or his phallus inside the maternal body. This is the phantasied danger to which the patient responds. It is covered by the general term castration anxiety, but the danger corresponds to the specific content of the fear which the patient experienced when he was entertaining the phantasy as a child. On the other hand, if an already established sublimation, like the pursuit of a profession, loses its secondary autonomy (Hartmann, 1950) and becomes involved in conflict and symptom formation, closer examination of the data usually reveals the regressive reactivation of some more primitive phantasy expression of the unconscious instinctual wish which originally formed the basis of the sublimation. The danger to which the ego responds with symptom formation is related to the content of the reactivated phantasy.

The phantasies which accompany masturbation are often of special value in understanding neurotic behaviour, character traits, and symptom formation. Certain distortions of ego function which form part of delinquent adolescent behaviour can be understood as an acted out, dramatic representation, of a suppressed masturbation phantasy (A. Freud, 1949). An analysis of the details of the masturbation phantasy often gives insight into the precise

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structure and defensive function of a symptom or a character trait (Arlow, 1953).

Summary

The essential point of this presentation can be summarized very briefly. In the analysis of symptoms the specific danger which the ego is warding off must be carefully delineated in relation to the emergent instinctual wish which has been regressively reactivated and which has become the source of conflict. Both the nature of the id impulse and the content of the threat which it signifies are represented at some level of psychic activity in the form of a phantasy. The

phantasy represents a specific version of how the ego integrated the demands of all components of the psyche and of reality. The phantasy reflects in its composition the immature state of ego functions and the misconceptions of danger current at the time when the id wish pressed for gratification. In analysing a symptom, therefore, it is essential to be able to place the underlying phantasy in its proper context in the history of the patient. Because a considerable degree of ego development is necessary for the structuring of intrapsychic conflict, the basis of symptom formation in the psychoneuroses is to be found rather late in the period of infantile sexuality.

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SERIOUSNESS AND PRECONSCIOUS AFFECTIVE ATTITUDES¹

By

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We consider seriousness to be a preconscious affective attitude. In this paper we shall discuss its genesis, development, structure, and functions. In particular we intend to relate it to the preconscious, autonomous, conflict-free ego functions. In this connexion, seriousness has similarities with many other preconscious affective attitudes.

The topic of the preconscious attitudes and of preconscious contents in general is a subject which has come to greater prominence in relatively recent years. As Hartmann (1939) has pointed out, the preconscious has as much to do with the normal aspects of human functioning as with the psychopathologies. The autonomous processes of the preconscious generally are not dealt with extensively as a subject of analysis, since they have been looked upon as part of the normal, healthy aspects of the individual. But a great portion of our life experience is ruled by the attitudes, habits, and characteristics deriving from the preconscious. The style of life and the value systems of the individual have their operational bases in the preconscious area. In each individual, patterns of reaction play a part in the development of a set of attitudes, beliefs, prejudices, and biases. These take form within the preconscious through the development of the ego-ideal objects and ego-ideal values. When, as often occurs, they are contradictory or inadequate, they lead to difficulties in integration. The values come about through a process of generalizing and abstracting from particular and concrete experiences with important individuals. Thus the preconscious becomes the repository of values.

If an individual were to lack the development of fixed, predetermined attitudes, his life would be infinitely more complex. The psycho-economic gain alone makes advantageous the

development of an automatically functioning set of patterns and values. Otherwise, the individual would be required to meet each new situation without the guidelines developed from past experiences. He would, under such conditions, have to expend a great deal of energy on the determination and/or adoption of a stance, in his attempts to comprehend each situation and cope with each problem. The task of the ego would then be of such great dimensions that the individual would almost certainly become overwhelmed, if not confused and disoriented. Thus, such a person would not be able to function in a complex society, except through a wholesale drain on his ego resources.

In looking at the autonomous, conflict-free functions, it seems to be possible to split the content of this sphere into two parts:

(i) Those which Hartmann refers to as primarily autonomous functions normally developing free of conflict are: perception, intention, object comprehension, thinking, language, recall phenomena, productivity; and the well-known phases of motor development: grasping, crawling, walking, talking, plus the maturation and learning processes implicit in these. Since these, in the main, develop in the individual without involvement in conflicts and defences, they form a basic aspect of the conflict-free sphere. These, however, refer to only one portion of the conflict-free sphere.

(ii) Another portion of the preconscious autonomous conflict-free ego is secondarily autonomous. It has to do with affectively toned attitudes, which, while they share 'space' topographically as preconscious, and structurally as part of the ego, have different genetic roots. Secondarily autonomous prejudices, biases, habitual or customary tendencies, and commitments to ideas, it seems to us, derive from either

¹ Another paper now in preparation discusses topographic aspects of affectivity.

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resolution of conflict plus neutralization, or from identification with patterns from important other persons in the individual's life.

In contrast to the conflict-free ego sphere, part of character derives from 'resolved conflict' aspects of functioning. That is, in normal persons, the conflicting impulses are dealt with by defence mechanisms adequate to that task for that individual and form a method of handling specific aspects of the individual's life. Since these serve adaptational functions, their use is continued. The result is a pattern which is consistent for an individual, and which, by virtue of its existence, allows each individual to save the amount of energy which would be expended in meeting each new situation or stimulus. The conflict aspect and the libidinal basis continue in the process. Thus, in the characterological defence, the libidinal or aggressive forces continue to participate and require of the ego that countercathexes be supported by further energy supplies. Even so, there are psycho-economic advantages here, for patterned reactions consume less energy than would be involved in developing totally new patterns.

Both aspects of the autonomous ego, once the formation has developed, operate in a similar manner and for similar purposes. This distinction between primarily and secondarily autonomous functions is of importance for discrimination between those which might more readily be dealt with psychotherapeutically and those which can become subject to the domination of the conscious ego only rarely. Both primarily and secondarily autonomous aspects of the ego differ from the resolved conflict character-defence patterns in that they ordinarily operate free from a direct connexion with libidinal needs and drives. In neurosis, these patterns may become reconnected directly with libidinal impulse as a result of some conflict. In schizophrenia, particularly in the borderline states, heightened awareness of functions which are usually autonomous increases, and thus creates an ego task of terrifying dimensions, thereby serving as disruptive and disintegrative influences.

For the foregoing reasons, we, in contrast to some writers, suggest that bias and prejudice, as well as other preconscious affective attitudes, are part of a requirement for healthy, complex ego functioning. These normal and necessary patterns develop through correct perception and apperception of reality under the guiding and modifying influence of elevated but reasonable ego ideals plus a firm, just, consistent superego.

Prejudice, as with any other defence activity, serves an adaptive function. The demand that there be no prejudgement amounts to the demand that there be no freedom for choice or preference. Thus, a truly unprejudiced person, as mentioned above, is a person who is unable to function, except in behaving as though all situations and all relationships are new. Infants and borderline psychotics are the only true members of such groups. Schizophrenics and adolescents may at times approach this condition.

A second group who might be called unprejudiced consists of those who believe they are not prejudiced, but on close examination turn out to have a set of attitudes and beliefs which are not available to their consciousness. These may say they are unprejudiced or even that they are against prejudice, the latter itself being a way of expressing a prejudice against prejudice. A third group is that in which the individuals are well aware that they are prejudiced, and are willing to accept their known biases as a part of themselves. This is to say that an attitude for something often requires a corollary attitude against something else.

In great part, the preconscious attitudes serve as guidelines for the everyday problems of living. They determine the manner of approach, the manner of considering, the time, quality, and quantity of cathexis, the locus of involvement; and they lend a stability and an economy to the psyche. It seems to us that only through the development of a vast group (of patterns) of consistent preconscious attitudes, beliefs, judgments, opinions, biases, and prejudices can an individual achieve normal function. It is only in persons in whom such a development has occurred to a very advanced degree that there is sufficient residual psychic energy for creative or even productive mental activity. In this activity the readiness of controlled interchange between conscious and preconscious determines the quality of the thinking (Kubie, 1958). This interchange depends partly on the amount of surplus psychic energy available to the individual. Therefore, normal psychology is dependent primarily on the function, process, and content of the preconscious in its relation to the conscious and to the outer world.

Seriousness, as one of the important preconscious attitudes, can serve as an exemplification of secondarily autonomous preconscious affective attitudes. The development or failure of development of seriousness, pseudo-seriousness, and aberrations of seriousness have their

counterparts in other affective attitudes. We think of seriousness both as a preconscious affective attitude and as a state of the ego which partakes of the qualities just described. Seriousness in its function as a determinant of cathexes is, in our opinion, one of the most important of the preconscious attitudes. It lends a quality, an overtone, to all the psychic processes.

Let us first describe seriousness. Seriousness refers to a state of being of some sort. Simply put, it is an ego state. We speak of ego here in the extended sense, as Freud sometimes used the term when by ego he really meant the whole psychic apparatus. Seriousness is a complex, affective state involving a particular attitude towards both the self and the external world. It is an attitude which imparts a certain quality to the way a person relates. It is related to the judgement of important; whereas, generally speaking, in normal mental functioning the judgement of unimportant is related to a non-serious attitude.

Spitz (1957) has shown that true affirmation cannot exist until psychic development has reached a point where the individual is able to conceive of the semantic *no*. In like manner, true seriousness cannot exist until the individual is able to conceive of the non-serious. This able to conceive of the non-serious. This conception gives a perspective as to the complexity of seriousness, which in turn demonstrates that a great deal of psychic differentiation has had to occur before seriousness, in its developed sense, can become a part of a set of attitudes. This is true because the capacity for judgement has to exist before the judgement of 'important-unimportant' can be made.

The judgement 'important' is, however, only part of seriousness. More is required. The answer to the question 'What more is required?' is that once the judgement 'important' is made, the mobilization of aggressive and libidinal cathexes must occur. This involves attention of a particular quality to the issue which has already come to attention and has been judged important. That which is judged important to an individual is responded to with a cathexis and is accompanied by inner experience of reverence, awe, soberness, decorousness, depth, weight, gravity, sedateness, solemnity, earnestness, or sombreness. These accompanying qualities vary in combination in specific instances, even for the same individual, but they are true whether the attitudes involve a person or whether they involve subjects, ideas, topics, or events.

In the absence of seriousness, as a general

characteristic of an individual, we should consider a psychopathological state to exist. This may either be in the nature of a lack of development of the individual, or due to some kind of neurotic conflict within him. The absence of seriousness and neurotic disturbances of seriousness will be described at greater length.

Genesis of Seriousness

It seems likely that everyone, excluding those with severe cortical defect, has the basic anlage for the development of seriousness. The capacities for attention and sensation and use of the perceptual apparatus in combination with the self-preservative instincts seem to be the basic materials. Later the introjects from which follow definition of self—not-self bring with them concepts of goodness and badness and a sense of identity. That is to say, qualities of the self are developed.

Next, further differentiation brings the development of better secondary process. Let us elaborate this. The earliest capacity for attention rooted in the self-preservative instincts forms the base. At the behest of the self-preservative instincts, the infant attends, without any conflicts, to whatever is necessary to counteract threat or satisfy needs. After some development, a sufficient basis is formed for development of self-other differentiation to occur. Only following this development can the attitudes of others be identified with, and qualities of self and other be developed or perceived.

The existence of seriousness as an attitude is primarily the result of identification with early objects who took both themselves and the infant seriously. Where this has not occurred, it will be exceedingly difficult for a child to take himself seriously. When the child's existence, sense of worth, interests, etc., are considered seriously by the adults around him, he himself can adopt a serious attitude toward his existence, worth, interests, etc. This attitude allows him to apply a realistic as opposed to a magical or non-serious approach to himself. French's (1937) description of the development of the reality sense has relevance here.

When it is necessary for the individual to ignore realities, this may usually be traced back to some previously seriously taken reality which has preempted the ego and reduced the possibility of taking the current reality seriously. Thus both reality testing and interpersonal communication are hampered. Where one lacks

a basic capacity to take oneself seriously, one cannot take others seriously either. A non-serious attitude leads to a sense of silliness, playfulness, inconsequentiality, inappropriateness, or flightiness. Thus, the attitude of seriousness forms a basic element in development of the kind of self-awareness and self concept.

Economic Aspects of Seriousness

The normal function of seriousness in the preconscious autonomous processes is that of effecting a psycho-economic saving. Predetermining the attitudes of readiness for specific behaviour provides the individual with surplus energies which he may use for productive or creative activities. The stress of critical events may be so great as to justify the concentration of almost all the attention upon the critical issue. Such a state of affairs is usually of short duration; otherwise, it occurs at the expense of cathexis to other important everyday activities, and this curtailment is too great for ordinary living. Such narrowness, if prolonged, is the result of neurotic conflict.

Cathexis may be thought of as the concentration of charges of energy upon various psychic contents such as self- and object-representations, inner and outer perceptions, thinking, etc. Perception and judgement make the determination of important-unimportant. When the judgement 'important' is made, the attitude we call seriousness is activated, and in turn regulates how energies will be deployed. It can, of course be said also that what we take seriously is the same as what we consider important. 'Important' belongs more to the cognitive and seriousness more to the affective sphere. Seriousness determines what is to be invested and where the interest will lie; it determines the kind of cathexis. Where a direct cathexis may be made to an object, subject, or activity, the actualization of the capacity for seriousness is at its greatest strength and intensity. A pseudo-seriousness exists where, for whatever reasons, a direct cathexis is not made, but an indirect cathexis is developed—that is, where a cathexis is to some object, subject, or **topic at a tangent** to what is apparently the main element.

Structural Aspects of Seriousness

We think of seriousness as being a psychic entity, a preconscious autonomous function, which is made up primarily of ego mechanisms

derived from instinctual self-preservative impulses, but through the process of development has moved into the sphere of the ego. This subsequent development occurs through the introjects, hence from superego elements and particularly from the ego-ideal attributes. These superego implications, which have considerable importance to the individual's everyday life, have to do with the capacity for taking certain things seriously enough for a commitment to be made, a loyalty built, or an enmity formed—any of which may be fixed for at least long periods of time, if not permanently.

The superego contains mainly punitive introjects, that is, parental threats of punishment for transgressions against parental prohibitions. If the parents are serious about what they prohibit, the introjects will be likely to have that same character, and the individual will feel seriously held accountable.

The content of the ego-ideal is mainly made up of expectations and hopes, and comes to be that which we wish to be. The superego is often identified as archaic and unconscious, but much of the ego-ideal is also unconscious. If the parents seriously, though non-punitively, expect the child to be what they appear to want it to be, the child will take these expectations seriously. Through these introjective mechanisms seriousness will be structurally built into the personality.

Object Relations and Seriousness

It seems clear that interpersonal relationships depend in great part on the attitudes of seriousness, that if the nature of the attitudes is not that of serious consideration of the other, then the relationship will be a very poor one. Individuals vary in their capacity to take others seriously, and a variety of elements determine this capacity. If an individual lacks the capacity to take himself seriously, he must then lean on group membership as a basis for determining whether or not he takes the other seriously. Such persons have learned at some point in their lives that since they do not take themselves seriously, their only way of determining whether to take another person seriously is in terms of group membership. Caste, class, profession, religion, race, political affiliation: these form the signals for such persons.

It is only when one takes another seriously as an individual that effective communication can occur; that is, real friendship or real enmity cannot exist without seriousness. The distinction between the serious and the non-serious is

the difference between transitory and permanent relationships. Seriously taken commitments yield a permanence, while the transitory, accidental alignments result from inability to cathect seriously. That is, without seriousness, friendships and enmities in a deep sense are non-existent. With seriousness, an enduring alignment is possible politically, interpersonally, ethically, religiously, and so on.

For one person to love another, he must regard that other seriously; to love another maturely he must seriously regard the subjectivity of the other. Marriages based on serious regard for group membership or other external criteria, rather than for the individual, are far different from marriages in which the other is taken seriously as an individual. The attitudes towards family as a pattern versus attitudes towards family as made up of seriously regarded individuals form the basis of a continuance through generations of one or the other approach, for identification and learning are at the heart of the matter of seriousness.

For normal development in interpersonal relations an individual must develop a sufficient sense of seriousness about himself. This develops through interaction with the parents, and results in either the individual's adoption of the attitude of the parents towards himself, or his learning in some kind of interaction with the parents what their attitude is towards himself. If this does not occur it is as though an area of his ego remains immature. There is very little likelihood of his then developing interpersonal relationships of a satisfying quality, of being able to apply himself to his work in an adequate way, of developing an attitude or set of attitudes towards himself which are of healthy and satisfying quality. The vulnerability of such persons to psychopathologies is immensely increased in such circumstances.

Seriousness and Other Ego Attitudes

Seriousness is a prerequisite for varied affective attitudes such as respect, reverence, considerateness, gravity, the capacity for solemnity, dignity, etc. It is hard to make an exhaustive list of these qualities of which seriousness is a necessary ingredient. The absence of seriousness produces certain pathological traits in the character structure: frivolousness, pettiness, silliness, etc. The ego's attempt to defend against these traits leads to pomposity, the pontifical, and inappropriate earnestness.

Seriousness in Ego Handling of Aggressive and Libidinal Forces

Unless an individual can take himself seriously there will be a profound disturbance in loving. He will not believe his love is worth anything, so he can neither give love nor receive it. Likewise, if a person cannot take himself seriously, the deployment of aggressive energies will be disturbed. Therefore, he cannot seriously enough believe in anything, so that he cannot fight for what he values, or fight against what he rejects. Insufficient seriousness about others will lead to disregard of them, either brutally or indifferently. Or in such conditions as the paranoid states, others will be taken excessively seriously as sources of threat unmodulated by reality, therefore feared and hated. Here the disturbance in seriousness disturbs the perception of reality.

Commitment to ideals and principles requires seriousness. Seriousness is at least part of the source from whence comes the courage to stand up at personal risk for some cause or ideal or person or group—in short, for what he believes is right. For a man to court a woman, to take the risks of rejection, disappointment, hurt, requires him to take his manliness seriously. This gives him the courage to be a man. In like manner, a woman needs to take her womanliness seriously in order to participate adequately in life as a woman.

Psychodynamics of Seriousness and Non-seriousness

In patients who manifest a generally non-serious attitude, we see most commonly one or other of two patterns. The first is that of an immature structure: one not developed to the point at which the person can take things seriously. The second is a defence against conflicts in which the non-serious attitudes operate to avoid the overwhelming threat to the affects which would be aroused if the individual were to take that content seriously. This second pattern reaches, in some, the point of being an immediate automatic response in situations in which there is even the slightest danger of feeling serious. The experience in childhood of not being taken seriously by the significant adults is reflected in the structuralization of the psychic apparatus, so that the individual will not expect to be taken seriously. In this connexion, it is believed that the pregenital experiences with the mother are of greatest importance. The expectation of not being taken seriously will then have

the character of a repetition-compulsion. Indeed, such persons tend to feel quite uncomfortable if taken seriously by others.

When an individual lacks the capacity to take himself or his activities seriously, but early experiences forced him to make this adaptation—that he regard everyone else seriously—he will continue to allocate excessive seriousness to others and not enough to himself. When the seriousness is allocated to self, other, and situation, a normal seriousness will result. When seriousness is allocated to less than these, some pathology will result. That process is usually unconscious, and may occur on the basis of previous preemption of determination as to what is or is not to be taken seriously. The interpersonal relationships of such persons take a major part of their form from this particular dynamic. It is likely that the ‘teasees’ described by Margaret Brenman (1952)—some individuals who moved from one group to another and were promptly teased serially in each group by persons who had never known them before—were of this kind.

The ability to be momentarily non-serious to relieve a threat, demonstrates the healthiness of the ego in its relation to the superego. This may occur normally without discomfort as a means of giving a breathing space before again tackling whatever problem has arisen. Momentary distance adds perspective, and some flexible shifting between being all serious and all non-serious is desirable. Flexibility of a sort that allows a kind of psychic play is a prerequisite for creative activity as well as humour.

When an individual continually avoids a non-serious attitude and demonstrates a grimness about his approach to work or any activity, we may suppose that an overly rigid superego has a destructive grip on the ego, or that he is afraid that if he relaxes his seriousness even momentarily he will lose it altogether. Such persons are anxious, humourless, depressive. They are psychologically vulnerable if that which is so tenaciously taken seriously should be lost by physical illness or other extraneous circumstances.

Freud pointed out that a joking attitude, that is, a particular variety of non-serious attitude, permits the lifting of repression. If some ego-dystonic content of the mind is repressed because it is too painful to be admitted to consciousness, the energy consumption in anti-cathexis can be reduced by allowing the repressed to return through taking that content jokingly or non-

seriously. These considerations lead to an understanding of the part seriousness plays in the defence mechanisms of repression in a general way. That mental content which is taken as a serious threat to ego integration must be repressed. Consequently, seriousness plays a part in the ego's dictating which mental content must become the target of the counter-cathetic energies.

Pathologies of Seriousness

It might be possible to evaluate the individual's approach to anything in terms of a continuum from non-seriousness through healthy seriousness to pathological grimness. Seriousness derives from the following sources: identification with the attitudes of seriousness in either superego or ego-ideal figures; through the experience of being taken seriously by others; or the experience of taking seriously something which is supported by later experiences.

Non-seriousness may occur when there is a cathexis to something other than that object, entity, or idea which is being perceived. Seriousness is, in such a case, about something tangential to that which is supposedly being considered. As a consequence, there may be a pseudo-seriousness, a mockery, or a flippant attitude involved. Since the reality important to the individual gains the greater cathexis, the pseudo-serious can at best produce only an inexact copy, and therefore takes on the quality of mockery or even, when conscious, fraudulent seriousness.

A non-serious attitude usually results in non-grave, silly, fatuous, frivolous, trivial, gay, light, petty, worthless, jesting, or deceiving behaviour and approach. The fact of a non-serious attitude toward self, in comparison to an ego-ideal which is taken seriously, leads to a self-attitude of worthlessness or of self-contempt, or to a shallowness of personality. The psychic yield of self-contempt is often the affect of shame, and the behavioural consequences, while varied, are almost always pathological.

The sense of worthlessness in some persons makes any taking of the self seriously produce feelings of guilt. If others take them seriously it induces in them a sense of shame for not being, in their own perception, worthy of that serious regard. They therefore swing between the two extremes of a neurotic dilemma, wanting to be taken seriously and avoiding being taken seriously, for there is pain with either solution. In some persons the seriousness in attitude has become so narrowed that they can be serious

about only one narrow spectrum of activities or subjects or objects in their lives. Seriousness about a specific work activity, at the expense of other activities in the individual's life, curtails freedom of functioning, regardless of the value this may have in the specific activity which is taken seriously.

It may be that the most common effect of non-seriousness is in persons who are unlikely to be seen in any kind of psychotherapy. That is the group of persons who take very little seriously. They have a limitation of concern about themselves, events, and objects. Their lack of seriousness differs from boredom especially in the non-conflictual aspect of its basis. Such persons, being 'untroubled', lead shallow, non-thoughtful, relatively uninvolved lives. They are those who remain calm when others are excited, because they do not understand the situation. To classify them as schizoid is to classify far too great a bulk of the population in that pathology.

Seriousness and Psychopathologies

There are several categories of pathological conditions in which defects of seriousness seem to occur. The first is masochism, which has already been described to some extent. In this, the seriousness about self-punitive activities and attitudes is given the greatest importance, even though in such persons the guilt which acts as the instigator for the masochism tends to remain at an unconscious level. In depression, in contrast, the guilt floods the consciousness and is given a disproportionate seriousness. The seriousness is towards the feelings of guilt, almost always in an unrealistic way. If the psyche is flooded with unmodulated affect of guilt, the result is that not the totality of the psyche, but instead only a small portion of the psychic apparatus and content and reality is taken seriously.

In paranoia there is at base a profound lack of sense of worth coupled with a feeling of not being able to take oneself seriously. This develops a conviction that no one else will take one seriously. Possibly this too has developed from not having been taken seriously by parents in early childhood. The individual then develops a wish to be taken very seriously by others and builds a delusional system as a way of manufacturing a pseudo-seriousness about the self. As a way station in the process, there is a heightened seriousness about hostility.

In another group, the 'as if' and the psycho-

pathic personalities, there is a basic lack of sense of worth, of seriousness about the self. The solutions used by these two types of persons differ slightly. The 'as if' person attempts to take on the behaviour and the qualities of those around him as a substitute for his own lack of sense of worth; the psychopath pretends to take others seriously, while he actually takes seriously only his attempt to receive gratification from the other through his manipulation. In all these pathologies, seriousness about reality is either missing or quite insufficient.

It seems likely that the pathologies of seriousness may be seen in any of the psychopathologies. Since seriousness is a complex psychic entity, a breakdown in any of the psychic components affects the attitude of seriousness. Therefore, in schizophrenia, partialization of seriousness may occur. In mania, there occurs what may be described as either an overseriousness about a part of reality, or a lack of seriousness about the whole.

Seriousness in Psychotherapy

There is a group of psychotherapeutic problems having to do with seriousness and the attitudes of the therapist which are communicated to the patients. It is necessary for the psycho-analytic patient to develop an attitude of seriousness about his mental functionings, about his self, and about the therapist. If this attitude is not present at the beginning of therapy, its development is a prerequisite for psychotherapeutic work.

It is the analyst's ability to regard seriously the patient and matters of concern to the patient—forming a core of significant communication—that promotes analytic activity. Loewald (1960) points out that such a resumption of ego development is a part of analysis. In the therapeutic process the serious attitude of the therapist about the patient and his problems often surprises the patient. In every case this occurs when the patient has not been able to take himself seriously. The paranoid, for instance, at such times (that is, when he realizes that the therapist is taking him seriously) will invert and then project. That is, if both therapist and patient for a time regard the patient seriously, the paranoid patient may say, 'I have the impression you don't like me, that you're against me'. The depressive, when he perceives the serious interest of the therapist, increases the feeling of guilt that he has and may become more depressed or lapse into silence because of his

feelings of unworthiness. The hysteric symptoms also may increase in such circumstances. The obsessive-compulsive's symptoms increase or, more frequently in the mildly obsessive-compulsive, distancing and isolation from the therapist occur. It is at such a point in therapy that the problem of seriousness must be dealt with, at least indirectly, in order that further progress may be made.

For a patient to be able to work effectively on his problems, he must take them, his symptoms, and his conflicts seriously as they exist in his daily life. He must be able to accept the therapist's serious interest in him and his problems. The question of seriousness must be dealt with before communication can occur.

The properly functioning attitude of seriousness in the therapist, which will be mainly preconscious, except when the therapeutic difficulties are acute, will more or less automatically determine appropriately the amount of weight to give the patient's feelings. For instance, the patient's hostility will be understood as transferred, and not be taken with literal earnestness, but taken seriously nonetheless as a reality not to be disregarded, albeit an irrational one.

Summary

This paper describes the preconscious affective attitude of seriousness as an example of the development of secondarily autonomous functions. Such functions have similarities to both primarily autonomous functions and resolved-conflict characterological formations in several ways. They differ, however, both in the process of their creation and in their amenability to analytic procedures. The primarily autonomous functions, together with the characterological patterns, serve as the basis for decisions and determine tendencies for the preponderance of activities in normal daily life. The psychology of normal functioning must therefore lean heavily on an understanding of the preconscious.

The secondarily autonomous functions are, in this paper, exemplified by the affective attitude of seriousness. The development of seriousness begins in the anlage of self-preserved instincts. Through defusion and elaboration, and either by identification with parent figures and or through patterns developed in interaction with others, one becomes capable of seriousness. Failure in such development creates a severe pathology, which by its very nature may at worst preclude analysis and at best become a requisite first development in treatment. Maldevelopment of seriousness may occur in several ways. The non-serious may be a result of inability to cathect, a result of defence against seriousness, or one of the forms of pseudo-seriousness outlined earlier.

The development of seriousness begins in the earliest neonatal experiences with the mother, and continues through the successive phases of psychosexual development and optimally may continue development until senescence. In short, the full maturation of seriousness is reached late. It is successively better formed through adolescence, young adulthood, and later maturity.

The relevance of seriousness to interpersonal relations and communication, ego attitudes, and psychopathologies is briefly described. In treatment, the pathology of seriousness requires special attention by the analyst.

The implicit hierarchy of amenability to therapeutic efforts places the ego-alien conflict formations as most easily treated, followed by the resolved-conflict formations which must first be made ego-alien; these are followed by the secondarily autonomous functions which require additional tasks: deneutralization, a shift from ego-syntonic to ego-alien, and usually some disidentification from superego and ego-ideal objects. These additional tasks, while formidable, are necessary aspects of the analysis of secondarily autonomous functions such as affective attitudes, e.g. seriousness.

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THE PROBLEM OF THE ASSESSMENT OF CHANGE IN PSYCHOTHERAPY¹

By

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The assessment of change in psychological variables is a core problem in clinical research in any aspect of the behavioural sciences—whether it be in personality growth and development, in psychosomatics, in education and learning, in psychodiagnostics or in psychotherapy. The change brought about in personality functioning under the impact of psychotherapeutic intervention is often taken as the prototypical expression of this issue.

Most simply (and naively) this is expressed as an inquiry into the effectiveness of psychotherapy. The questions are: Does psychotherapy work? If so, how well does it work, to what extent and with what kinds of patients? And, in deference to the scientist's expected quest for controls, the question is often added: How well does it work, as compared with the natural history of the same morbid state left untreated? Asking, and expecting answers to questions set in these terms, is clearly based on a series of (at least tacitly) agreed-upon assumptions. These are that there exist *currently accepted* criteria of three kinds: (1) criteria of illness—specifications of the degree and kind of deviations that merit the designation, pathological; (2) criteria of a state of ideal mental health (called 'positive

mental health' in the current literature (Jahoda, 1958)); and (3) measures of improvement as the degree to which the patient has diminished the gap between his state of mental illness prior to treatment and these desiderata of mental health.

Obviously, of the three, we possess only the first—specifications of criteria of illness—and this is the whole body of knowledge of psychopathology and psychodynamics.² By comparison, knowledge of what constitutes the mentally healthy personality, the normal mind, or the 'genital character' (however one puts this) is fragmentary, tentative, and not as yet encompassed within a conceptual framework that gives coherent meaning to the propositions already advanced, that posits interrelations between them, and that points to gaps in data or in theory that need filling.

This is not to say that a literature has not begun to accumulate in this area. Jahoda (1958)³ in a monograph entitled 'Current Concepts of Positive Mental Health' prepared as the first in the series for the survey of the Joint Commission on Mental Illness and Health, undertook to review critically and to systematize the various ideas advanced in this literature to date concerning the criteria that characterize the state of

¹ This paper, from the work of the Psychotherapy Research Project of the Menninger Foundation, was presented in a condensed version at the meeting of the American Orthopsychiatric Association in San Francisco, March 1959; and then read in full in essentially its present form at the meeting of the Group for the Advancement of Psychiatry, Committee on Research, in Asbury Park, April 1959.

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² We do not wish to enter here into the still controversial areas surrounding agreement on what constitutes, defines, and limits mental disease. To the usual assumption that the definition must rest ultimately on symptoms or behaviours, Jahoda (1958) states the qualification that anthropologists tell us of generally accepted behaviour in some cultures that Western civilization would regard as symptomatic of mental disease... evaluation of actions as sick, normal, or extraordinary in a positive sense often

depends largely on accepted social conventions.' These anthropological researchers have indeed made the indisputable point that in order to understand a given behaviour pattern it must be considered within the cultural matrix in which it occurs. What they, at the same time, so often fail to consider, however, is the specific meaning of the behaviour to the individual. Behavioural similarity does not necessarily mean dynamic identity. We shall assume in this paper that specification of the *meaning* of the behaviour under scrutiny—its meaning both in terms of intrapsychic structure and in relation to both the (interpersonal) pressures of the environment—resolves the seeming paradox created by the 'cultural relativist' approach; we shall also take for granted that a degree of consensus exists on the criteria for mental illness that we cannot as yet assume holds for mental health.

³ In addition to Jahoda's monograph on the subject, I am indebted to two colleagues, Martin Mayman and Herbert J. Schlesinger, who have each prepared thoughtful critiques of the issues involved in attempting to arrive at agreed-upon concepts of normality and mental health.

positive mental health. In this essay we will set forth our own ideas about the problems inherent in attempting to assess psychological change within the context, first, of a critique of the degree of success achieved by a number of these major efforts to deal with the concept of mental health, including Jahoda's comprehensive review.

Jahoda rejects, as do most thoughtful writers on the subject, the simple assumption that mental health and normality is merely freedom from symptoms—a concept that had been formed mainly as the antithesis of neurosis. Hartmann (1939) states that mental health must be *more than* freedom from symptoms, which indeed need not always be absent. He says, in fact, 'a healthy person must have the capacity to suffer and to be depressed', and that 'typical conflicts are a part and parcel of "normal" development and disturbances in adaptation are included in its scope'. Absence of conflict is no requirement of health nor, conversely, does presence of conflict determine illness. Ernest Jones (1942), in making the related point that the test of therapeutic success in psycho-analysis is not simply the removal of manifest symptoms, goes on to state that 'it constantly happens in the course of analysis that the patient receives what might be called bonuses in addition to the actual benefit he expected on coming for treatment. . . . A thorough analysis, we know, has the effect not only of removing any manifest psychoneurotic symptoms, but of so dealing with the fundamental conflicts and complexes as to bring about a considerable freeing and expansion of the personality. In so doing it leads to changes of a general order in the character and even intellect, notably in the direction of increased tolerance and open-mindedness.'

There is agreement, too, that mental health, or normality, cannot be reduced to a concept of statistical frequency. The abnormal, in the sense of deviation from the average, cannot be taken to be synonymous with the pathological. Hartmann (1939) states as examples the fact that dental caries, no matter how ubiquitous, is none the less always pathological, and that, *inter alia*, the exceptional achievements of single individuals should not by virtue of that fact be brought within the scope of the pathological. Jahoda (1958) makes the further point that, even should one attempt a statistical definition of psychological health, basically non-statistical considerations would none the less intrude. This she states as follows:

'In order to establish a statistical norm, one has to define the population from which it is to be derived. And the choice of a population inevitably contains, at least implicitly, a non-statistical concept of health. One would not, for example, develop a set of statistical norms for an arbitrarily merged population including both so-called primitive and civilized societies, males and females, children and adults. Why not? Because it seems evident that the determining conditions of the same behaviours, the contexts, their consequences, and hence their meanings, to either the actors or observers, are often likely to be quite different in different types of society, or in the two sex groups, or in different age groups. It follows that in deciding upon a reference population one is at least tacitly considering the determinants, contexts, consequences, and/or meanings of behaviour relevant to its evaluation from the viewpoint of mental health.'

A third rejected criterion of 'positive mental health' rests in various states of well-being, often cast in poetic language, and usually reducing to some judgement of happiness and satisfaction. The obvious difficulty here resides in the 'tacit assumption that happiness or contentment need no special referent or qualification' (Jahoda, 1958). Jahoda here makes the useful distinction between an enduring happy disposition and the achievement of happiness in any and all circumstances. To affirm the latter would, she says, 'betray a naïve belief in the moral justice of all existing conditions'. In relation to this same question, Jones (1942) quotes Trotter to the effect that the conclusions of psycho-analysis would be more cogent if they did not so often imply an unthinking acceptance of the normality of the social environment. Trotter (1916) says, beginning with the concept of statistical normality, that 'the statistically normal mind can be regarded only as a mind which has responded in the usual way to the moulding and deforming influences of its environment—that is, to human standards of discipline, taste, and morality. If it is to be looked upon as typically healthy also, the current human standards of whose influence it is a product must necessarily be accepted as qualified to call forth the best in the developing mind they mould.' Hartmann (1960) specifically disavows happiness as an adequate objective measure of mental health. 'The appointment of happiness, or biological advantage, or any utilitarian aim, as a supreme moral value is still the expression of an empirically *subjective* attitude. It cannot be deduced from any data of biology, or of social science, or of any other science.'

Turning from all these manifestly unsuitable conceptualizations of mental health criteria, Jahoda presents six major categories of efforts to give psychological meaning to the notion of positive mental health that to her seem promising. These six sets of concepts, the major groupings that emerged from a thorough study of the relevant literature, are: (1) the attitudes of the individual towards his own self, (2) the individual's style and degree of growth, development, and self-actualization, (3) integration of personality as a central synthesizing psychological function, (4) autonomy, self-determination, or independence, (5) the adequacy of the individual's perception of reality, and (6) the style and degree of mastery over the environment. In assessing these proposed criteria, Jahoda is searching explicitly for empirical indicators along each of these dimensions, and she devotes a chapter to suggested research studies and techniques designed to put these propositions into empirical terms, suitable for clinical and experimental testing. She attempts, that is, to take the criteria of positive mental health out of the field of moral philosophy and into that of empirical scientific scrutiny.

That this overall attempt is incompletely successful is attested by the following statement in the latter part of the book, on the, up to then, deliberately postponed discussion of the problem of values:

'The discussion of the psychological meaning of various criteria could proceed without concern for value premises. Only as one calls these psychological phenomena "mental health" does the problem of values arise in full force. By this label, one asserts that these psychological attributes are "good". And, inevitably, the question is raised: Good for what? Good in terms of middle class ethics? Good for democracy? For the continuation of the social *status quo*? For the individual's happiness? For mankind? For survival? For the development of the species? For art and creativity? For the encouragement of genius or of mediocrity and conformity? The list could be continued.'

By this point the argument has come full circle. Jahoda has tried to delimit criteria of mental health and give them empirical psychological meaning. But she then tells us that when we take her intent seriously and call these psychological

phenomena 'mental health', we become inevitably plagued by the philosophical problem of value judgements. In fact, she concedes this explicitly by going on to state: 'All that is required from those working in the mental health field is to make explicit the values which induce them to select certain criteria.'

Psycho-analysts, too, have attempted to cope with the concept of mental health and of the normal mind. Two of these efforts, those of Hartmann and of Ernest Jones, will be singled out for discussion here because of the differing viewpoints from which they each approach this issue, and yet, the common problems they encountered.⁴ Hartmann (1939) avers the importance of the issue in this way: 'The concepts of "health" and "illness" always exert a "latent" influence on our analytical habits of thought . . . it often depends upon the analytical concept of health whether we recommend a course of analytical treatment—so that the matter is important as a factor in our judgement of the indications present—or what changes we should like to see effected in a patient, or when we may consider that an analysis is ripe for termination.'

Psycho-analytic descriptions of health had previously developed in two divergent directions. One was the goal of rational man ('where id was, there shall ego be'), stemming from the philosophic roots of analysis in the rationalism of the Age of Enlightenment. The other and contradictory goal was that of instinctual man (unhampered by neurotic inhibition), stemming from the philosophy of irrationalism of the romantics. Hartmann's position is that these are each partial aspects of an optimal state of health—optimal for the purposes of adaptation. In constructing this optimum, 'the rational must incorporate the irrational as an element in its design'.

It is from this viewpoint, from the side of the autonomous ego and its function of adaptation that Hartmann approaches the problem. 'The more we begin to understand the ego and its manoeuvres and achievements in dealing with the external world, the more do we tend to make these functions of adaptation, achievement, etc., the touchstone of the concept of health.' The health of a reaction must accordingly depend on

⁴ Both these authors discuss on theoretical grounds the possibility of arriving at value-free concepts of mental health, and in each instance, as will be indicated, fall short of making out a convincing case. No effort will be made here to discuss the contributions of those psychoanalysts, sociologists, and anthropologists—Erikson,

Kardiner, Parsons, Sapir, Kluckhohn, Davis, and others—who have particularly interested themselves in the effect of variation in cultural values and in social structure on the patterns of personality organization prized within specific cultures.

its usefulness from the standpoint of adaptation, not on a consideration of its conflict-determined origin. Even regression would not necessarily be the antithesis of adaptation, of health. There are successful progressive adaptations (development) and regressive adaptations (artistic creativity)—‘regression in the service of the ego’.

But it is evident that ‘the individual’s adjustment to reality may be opposed to that of the race’ and therefore ‘the concept of health may bear inconsistent meanings according to whether we think of it in relation to the individual or to the community’. Such considerations lead Hartmann to the essential qualification that ‘adaptation is only capable of definition in relation to . . . specific environmental settings’ and ‘the actual state of equilibrium achieved in a given individual tells us nothing of his capacity for adaptation so long as we have not investigated his relations with the external world’. Thus the question of adaptation to reality must at all times be set within the context of specific environmental settings—and with full knowledge of what constitutes the ‘average expectable environment’ for that individual.

By this stipulation, Hartmann has effectively eliminated the possibility of *directly* comparing the mental health or normality of different individuals, or even the same individual at different times. Zilboorg (1941) carried this limitation even further. He stated that ‘each so-called objective fact is actually a composite of the image of the object and a variable number of nihilistic and animistic qualities as well as direct projections of our own fantasies into the image’. Thus, mere equating of ‘objective’ environmental circumstance is no guarantee that outer reality will be the same for any two individuals. The meanings of any specific aspect of ‘objective reality’ will in fact differ both as it serves different drive-demands and as it mediates different societal values to which differential allegiance is felt.

Here we have come again full circle to the subjective valuations which comprise the cultural and social pressures that have moulded each individual’s personal philosophy, political sympathies, moral values, etc. In another publication Hartmann (1958) specifically acknowledges this point that mental health is, ‘in part, a very

individual matter’ and that ‘the commonly used criteria of health are obviously coloured by *Weltanschauung*, by “health-morality”, by social and political goals’—that is to say, by values. Most recently Hartmann (1960) specifically states, ‘I do not question that “health” is a value (although I do not discuss here its position in the hierarchy of values).’⁵

In distinction to Hartmann, who approaches the concept of mental health from the point of view of the autonomous ego, the approach of Jones (1942) is primarily from the point of view of the drives and their successful mastery. He affirms three attributes of the normal mind: (1) happiness, (2) adaptation to reality, and (3) (standing midway between these concepts) efficiency. Happiness he considers, despite Bernard Shaw’s dictum to the contrary, as the most important of the three. When happiness, in his sense of enjoyment combined with the capacity for enjoyment (or self-content), is impaired, this impairment is, he states, ‘always due to the triad of fear, hate, and guilt . . . and, the difficulties in development responsible for the inhibiting effect of this triad are in essence those of the Oedipus situation.’ By efficiency, Jones means ‘the fullest unimpeded flow of mental energies in the pursuit of activity. By adaptation to reality he means something quite different from Hartmann. ‘By reality we can in this connexion only mean psychological reality, and this in its turn may be reduced to mental contact with the individuals comprising the particular environment of the subject . . . these mental attributes depend on a feeling-relationship with other human beings.’ Thus restated as a positive social feeling-relationship with one’s fellows, this criterion becomes, to Jones, a consideration of the degree to which narcissism and ambivalence have been transcended in the course of development, a consideration of the problems of ‘love and hate, of friendliness and animosity’, and of conscience—in short, a problem in drive mastery.

In setting these criteria (which he sums up as ‘the criterion of unimpeded development’) for the concept of the normal mind, Jones has been avowedly seeking ‘an objective standard of normality’. He says, ‘The psychological problem of normality must ultimately reside in the

⁵ In this same publication which deals with the relation of psycho-analysis as a science to the problems of morality and of moral values in general, Hartmann (1960) does state that general moral values are of course distinct from specific mental health values. ‘It is obvious that there are many neurotics who are “highly moral” and

many, sometimes the same ones, who are socially useful while there are many “healthy” people who are neither the one nor the other.’ And in his therapeutic work the psycho-analyst’s focus is quite specific: he should ‘concentrate on the realization of one category of values only: health values. . . .’

capacity to endure—in the ability to hold wishes in suspension without either renouncing them or “reacting” to them in defensive ways.’ Yet in discussing his three attributes of normality, he acknowledges at several points the intrusion of value considerations. In regard to the criterion of happiness, he states, ‘there are difficulties in the way of using it quite empirically. In the first place a subjective judgement must come into play—apart, of course, from gross deviations—in estimating whether a given person is happier or less happy than is to be expected from his particular fate in life, in estimating how much influence is “normally” exerted by this or that misfortune, grief, or difficulty. We reach in this way the general philosophical consideration of the *value* of life, of whether it is more “normal” to be an optimist or a pessimist, to enjoy life or to endure it.’ In regard to adaptation to reality (meaning a positive social feeling-relationship to one’s fellows), he writes of the ‘most important social aspect, and one of the most difficult psychological aspects of the problem—namely, the assessing in the “normal” of the relations between the interests of the individual and those of society’.

This brief survey has been pursued to illustrate the chimerical nature of the efforts thus far to make the criteria for mental health into a set of solely empirical propositions and to divorce them from the realm of value judgements.⁶ No wonder then that Jones can correctly affirm ‘there is nothing in the method of psycho-analysis itself that binds the theory to any preconceived conception of normality in the average human mind’ (for ‘method’ we would here substitute the broader rubric ‘theory’). And it should be no more surprising that even the successful application of the psycho-analytic method does not necessarily lead to major shifts in values. Jones states this as ‘the disconcerting fact that analysed people, including psychoanalysts, differ surprisingly little from unanalysed people in the use made of their intelligence. Their greater tolerance in sexual and religious

spheres is usually the only mark of a change in the use of the intellect. In other spheres they seem to form their judgements, or rather to maintain their previous convictions and attitudes, on very much the same lines of rationalized prejudices as unanalysed people do. . . .’ Hartmann (1960) asks, ‘Would it be possible to say that people who have undergone an analysis have a uniform hierarchy of moral values, or at least very similar moral codes—perhaps what Plato expected of the sages? . . . It is evident that individual differences are not obliterated by analysis and that this is not less true of the moral aspect of personality than of its other aspects.’

Thus we can appreciate Jahoda’s statement that many scientists oppose scientific concern with mental health and that this opposition ‘is rooted in the conviction that the science of behaviour advances best by studying behaviour, without reference to whether it is “good” or “bad”’ (1958). Van den Haag (1959) separates out the questions that are usually condensed in such discussions as (1) the empirical (scientific) question: How must man act to attain specified goals? and (2) the value (moral) question: Should man act in that way? He cites the historic example of Machiavelli to illustrate the confusion of the two. ‘Just as the scientific purpose and method of the natural sciences were thought at first to be impious and immoral, so were those of the social sciences. . . . As soon as political science was refounded in the Renaissance, moralists asked whether it is permissible to do what Machiavelli did—in Bacon’s words “to describe frankly and without dissimulation what men do, and not what they ought to do”. . . . *The Prince* describes how power is achieved, held, and lost. . . . Machiavelli was particularly vulnerable to moral objections because his description of political behaviour was cast into the prescriptive form of advice to a ruler. His critics thought he must approve of the prince’s goal . . . whether or not he did . . . should be irrelevant.’

Van den Haag then sharply states the distinc-

⁶ This is not to say that there are no rules of thumb to act as general guides to clinicians in their judgements of the relative state of mental health or illness of one individual as compared with another. Such means exist, and they generally represent some convergence of the kinds of concepts listed by Jahoda in her six major categories in the direction of the Aristotelian view of the fulfilment of life. It is only when one attempts to pin these down into scientific categories and looks for generalizable laws that there emerge both contradictions (as between the fulfilment of the individual and the, at times opposed, fulfilment of the group), and points of seeming lack of

contact. The same difficulties incidentally inhere, as Jahoda likewise points out, in the effort to conceptualize precisely the criteria of physical health, although here too the examining physician is in most instances not in doubt the examining patient is healthy or ill. But as to whether a particular patient is healthy or ill. But what are the dimensions of physical health? Longevity? Physical strength and endurance? Organismic resistance to infection? All these are undoubtedly aspects of physical health, yet the ways in which they converge or fail to converge, or at times perhaps stand in contradiction to one another, are still unclear.

tion: 'The disagreement on what changes are worthwhile—on what ends we *should* strive for, individually and collectively—is not amenable to resolution by scientific means.' And it is illusory to think that 'perfect knowledge (as attainable by science) would eliminate conflicts about values—about what is good, or right, about what should be done, about the ends that people should pursue in preference to others'. To say, as Bentham did, that society should do that which is conducive to the greatest happiness of the greatest number is meaningless, for each society is very instrumental in determining what things (values) will make its members happy (the same dilemma that Jones, many years later, faced no more successfully).

If the nature of the normal mind and the dimensions of ideal mental health are thus not wholly empirical questions, then measures of improvement, as specifications of the extent the patient has progressed from his state of mental illness to this goal of mental health, must necessarily fall under the same shadow. Improvement is a complex concept that is not clarified by being cast into the disarming simplicity of three- and five-point global rating scales. It is linked not only to whatever standards and goals are selected to represent ideal health, but also to the (possibly) divergent treatment goals of therapist and of patient, and to the vantage point and partisan interests of the judge. It is a commonplace that patient and family (not to speak of the therapist) can disagree about whether a particular change represents an improvement—and to whom it does so, and according to what values.

It is for such reasons that we initially defined the operational task of our psychotherapy research project, not as the *evaluation* of improvement but as the *assessment of change* during the course of psychotherapy. The question with which this essay began (the usual statement of the core question of much of psychotherapy research)—How effective is psychotherapy?—was reset in the opening statement of our initial publication as our purpose 'to study the process and the course of psychotherapy in order to increase our understanding of how psychotherapy contributes to

changes in patients suffering from mental illness' (Robbins and Wallerstein, 1956). When the problem is set this way, we can study the empirical questions of *what* changes have taken place—the inquiry into outcome—and of *how* those changes have come about, or been brought about—the inquiry into process. In doing so, we can temporarily bypass (at least to a large degree) the value question of whether the changes discerned constitute improvement—and to whom, to what degree, within what frame of reference, and according to what values.

It should now be quite clear that we see the chief problem at this stage of psychotherapy research not as the selection of mental health variables for which operational indicators can be delineated that would lend themselves to the construction of an instrument for measuring 'improvement', but rather in conceptualizing what *kinds of changes* (in what variables of psychic functioning) we are interested in assessing in accord with the theoretical position (psycho-analytic) within which we seek to give meaning to the changes we shall look for. The problem, that is, is the conceptualization and selection of crucial variables, changes in which, as consequences or concomitants of psychotherapy, we attempt to assess within a theoretical framework that determines the relevance of these changes to each other and to the therapeutic course and outcome. Our theoretical frame of reference is psycho-analysis as a theory of personality and of psychopathology. Within the postulates of that theory, we have chosen by discussion and consensus those variables that we consider to be the crucial factors in the patient, in his personality, and in the dynamics of his illness, that together determine his suitability for psychotherapy, determine the differential prescription of the mode of psychotherapy (within the gamut of psycho-analytically-based psychotherapeutic methods), and that govern the predictions and prognostications that are made—explicitly or implicitly—about the course and outcome of the psychotherapy.⁷

In the original statement of the concepts of our project (Wallerstein & Robbins, 1956) we indicated that our research effort at this earliest point was to delineate and to define systematic

⁷ The factors in the patient chosen as our 'patient variables' are defined in detail in the section *Concepts* of our initial publication (Wallerstein and Robbins, 1956). Kubie (1958) in discussing this same issue of the criteria of change in psychological processes has cogently stated the total inadequacy of symptom relief and of change in

mood or affective states as, by themselves, sufficient indicators—though they are the variables most used in evaluation research. (He then goes on to propose variables of his own, which are quite different from ours, and—to us—operationally not definable to the same extent.)

cally and explicitly all those prognostic and evaluative criteria that govern the usual clinical operations of patient assessment and treatment planning—though often only tacitly, rather than explicitly. We stated then ‘the assumptions upon which these judgements and predictions are based are for the most part tacit, and only to a certain, though somewhat variable, degree directly stated in each case under consideration. At conferences, evaluative statements are offered, buttressed by a statement of some of the outstanding factors that, in the particular case, seemed to contribute to the formation of that judgement. Sometimes feeling, intuition, or experience is the expressed basis. We have attempted to *explicitly* define these criteria. . . .’

That is to say, we assumed that out of discussion based on clinical experience and on the theoretical knowledge underlying it, we could (1) come to a consensus about which of our clinical working concepts of personality functioning we deemed explicitly relevant to treatment planning and prognostication, (2) define these concepts in ways that allowed their operational application in a ‘clinically reliable’⁸ manner, and (3) arrive at a systematic explicit statement about the operation and the impact of each factor in each of the cases under research scrutiny.

A basic assumption of our whole research, however, has been that the course and outcome of treatment is determined not alone by the operation of one set of factors, the patient variables, but by the interaction of three coordinate sets of variables, including, in addition, what we have chosen to call treatment variables and situational variables. By *treatment variables* we mean not only the parameters of the treatment, the technical interventions of the therapist, the contents dealt with, and the goals sought, but also the attributes of the therapist that bear on the therapeutic process and the climate within which the patient-therapist interaction takes place. By *situational variables*, we mean the factors and events in the patient’s life situation that have specific meaning within his psychological life-space and which, in interaction with patient and treatment variables, play a part in determining the overall course and outcome of the therapy. Conceived in this way, situational

measures are not being used merely as criterion variables of therapeutic outcomes, but rather as factors that impinge on the patient and make for change, and that may in turn themselves be changed by the impact of the altering status of the patient during and after his treatment.⁹ (In this same sense, the specific psychotherapy is itself but a highly specialized and potent environmental influence [situational factor] interacting with the patient to alter his accustomed reaction patterns.)

The selection of both the specific treatment and situational variables for definition and assessment was carried out by the same method of clinical discussion and consensus, but with even less clearly demarcated conceptual guide lines. Psycho-analytic theory of personality and of psychopathology has reached a sufficiently mature and comprehensive position to allow rather precise variables of personality functioning to be separated, at least conceptually, and to allow personality malfunctioning to be understood in terms of distortions in the harmonious interplay of these variables. By contrast, psycho-analytic theory of therapy is still fragmentary, and what the relevant treatment variables are derives much less clearly from already charted knowledge. Within psycho-analysis, numerous controversies have raged about the nature of its curative principles (Alexander and French, 1946; Eissler, 1950; Gill, 1954). Our own selection of treatment variables, as spelled out in detail in our second report (Luborsky *et al.*, 1958), was based on those concepts of therapy we thought most relevant, both practically and theoretically, to current clinical practice at the Menninger Foundation (Kubie (1948) has reported a somewhat similar attempt to organize relevant treatment variables).

In this sense the actual selection of treatment variables was ‘empirical’, though certainly not atheoretical. On the other hand, not all the treatment variables selected trace their derivation to psycho-analytic theory of therapy or of aspects of therapy (for instance, theory of transference); some of the treatment variables (for instance, the climate of the therapist-patient interaction in its bearing on treatment course and outcome) derive from ‘self-evident’ or

⁸ By ‘clinical reliability’ we mean the kind of concurrence that is reached by clinicians who work together within the same setting and with a common frame of reference. For a discussion of the meaning of reliability in this sense, see Luborsky and Sargent (1956) and Sargent (1961).

⁹ For a discussion of the implications of this coequal valence given to situational factors as determinants of change in psychotherapy, see Wallerstein and Robbins (1958), Sargent (1961), and Sargent *et al.* (1958).

'common-sense' propositions. Our intent, however, as our research leads us to refine the relevance of such 'non-psycho-analytic' variables to the whole group of variables and to overall therapeutic processes, is ultimately to understand them in psycho-analytic terms—within a broadened and deepened psycho-analytic theory of therapy. Similarly, the life-situational variables, spelled out in detail in our second report (Sargent *et al.*, 1958), though we attempt to understand them within the psycho-analytic framework, owe much of the formal structure of their conceptual organization to Lewinian field concepts of life-space as a variable in experimental research in personality dynamics (Lewin, 1935).

In thus selecting variables in each of the three co-ordinate categories—patient, treatment, and situational—based on their hypothesized relevance to change in psychotherapy, we have, however, not been able to separate ourselves from value connotations as 'cleanly' as perhaps has been implied to this point. In regard to many of the patient variables—for example, motivation or severity of symptoms—we not only adjudge them relevant to prospects for change in psychotherapy but we also generally feel that it is 'good' for motivation to be strong, and not good, or 'bad', for the symptoms to be very severe. Yet we know that motivation for treatment can have many pathological determinants, and we know too of cases where the absence of expected neurotic symptoms bespeaks a more pathological organization of the character than would their presence.

To meet this difficulty, we separate as sharply as possible the assessment of each variable at each point in time (and also our judgement of the extent and direction of change in that variable over time) from the judgement that can be made subsequently as to whether that particular change is 'good', that is, a change in the direction of greater mental health; or whether the constellation of changes discerned in the whole group of variables represents an overall personality shift in the direction of greater or lesser health. With some variables, for example, anxiety (as we conceptualize it), this separation is relatively simple. We assess the intensity of anxiety in the patient, how it is manifest, the ways in which it is averted, bound, or discharged, and the degree of the patient's awareness of it or denial of it, etc. There is no research commitment to the general goodness of overall change in this variable in one direction or another. There are

probably as many patients in our research sample who would be healthier if they were more anxious, or could at least allow themselves to become more anxious, as there are those in whom a diminution in anxiety level would be looked at as a favourable indicator. With other variables, for example, insight, this separation is more difficult, since in general we of course hold to the proposition that the more insight the better. But we do not hold to this in any unqualified way, and it has certainly happened that we have judged that insight has increased, and have then specified not only the areas in which this is so, but also the ways in which the enhanced insight has been used defensively to ward off certain therapeutic directions and to hamper the therapy attaining certain sought-after goals.

Thus we cannot claim that our selection of variables is free of all implicit valuation, since therapy is always a valuative procedure and change in therapy is always anchored to value commitments. As researchers we can, however, attempt to make our assessment of change in regard to each of our variables apart from the judgement whether in that patient, at that time (and within the context of all the other simultaneous changes in other variables), the particular change is in a more or less healthy direction.

Once the specific relevant items in each of our three sets of co-ordinate variables have been selected and defined by this process of clinical judgement and consensus, based on clinical experience as set within a unifying theoretical framework, the research task becomes one of assessment of each of these variables in each case under study to determine the interactions among them that underlie the process of psychotherapeutic change.

We have stated elsewhere (Sargent, 1961; Wallerstein and Robbins, 1958) the consequences for this problem of assessment of the fact that our variables are not objective observables in the usual sense, but are rather constructs about intrapsychic functioning and psychological relationships that derive from the theoretical frame of reference within which the meaning of observable behaviours is judged. This way of conceptualizing our selected variables was stated as follows: 'Patient variables are not conceived to be behaviours, but constructs concerning internal constellations arrived at by judgements about the intrapsychic significance of behaviours. Similarly, treatment variables are not conceived to be techniques, but constructs arrived at by

interpretations of the meaning of particular therapeutic interventions and relationships. And again, situational variables are not conceived to be just reality events, but constructs concerning the meaning these reality events have within the psychological life-space of the patient' (Wallerstein and Robbins, 1958).

Since constructs are created and identified within a theoretical frame of reference by methods appropriate to it, they can be reassessed only by similar methods within the same framework. This was stated by one of our group (Sargent) elsewhere as follows: 'If psychotherapy is regarded as a matter of learning and conditioning, outcome will be measured in terms of learned adaptations. If it is conceived as a special case of social interaction, or of communication, change will be sought in interpersonal variables. If increased conscious comfort and self-acceptance are seen as the primary therapeutic goal, self-descriptions of feeling states will be prominent in the data. If theory recognizes such constructs as the ego, in which reorganization may come about with or without direct or immediate reflection in verbal report or behaviour, dynamic states and ego variables can be assessed only by the instrument through which they are apprehended: clinical judgement' (Sargent, 1961). In other words, the assessment of current status or of change in a given variable in the patient or in his psychological interactions is, in the last analysis, a clinical judgement by the observer or investigator.¹⁰

It then follows that, if the assessment of a variable is in essence a clinical judgement by a clinician observer, the change that is determined in a variable judged at two (or more) points in time is the measure of change in observer judgement. When we judge that a patient or an interaction or a situation has changed in some respect, we may be dealing with an actual alteration in the object of scrutiny, or with a change in the observer and/or his basis for judging, based perhaps on fuller data available at the second point in time, or on more adequate explanatory concepts. Whether an adjudged change in a variable then reflects a changed conceptualization of that variable based on new evidence or fuller concepts, or an actual alteration in the status and functioning of that variable, must

always be part of the clinical judgement. If new information comes to light that would alter the initial clinical evaluation and conceptualization on which the whole body of prognostication about psychotherapeutic process and outcome in that case was built up, such new data are necessarily encompassed within the effort to delineate the changes that have taken place. In such instances, not only are the reasons for the correction set forth, but also an assessment of the factors that kept the newer formulation from being evident initially.

If this whole basis of inference and judgement on which the entire research structure rests seems subject to such uncertainties, we should bear in mind that this is none the less the basis on which all our clinical work—psychotherapy, and the teaching of it through supervision—rests and progresses. Clinical research operates within the same conceptual and methodologic framework. It necessarily uses as the base for its inquiry what is accepted in clinical practice, trying slowly to increase the areas of reliability and certainty through making more explicit and subject to inquiry by various observers, with differing instruments, from different vantage points, and at different times, what has to this point been only implicit and known only on an intuitive or impressionistic basis.

To this end, measurement, in the sense of efforts at quantification, finds its place in clinical research to whatever extent it is applicable in each specific instance. In our own project, concerned with the assessment of change and the study of lawful covariation in three co-ordinate sets of variables deemed relevant to treatment course and outcome, we have, for instance, employed rank order statistics at each point in time, to facilitate interpatient comparisons of those variables that lend themselves to extrapolation along a more-or-less continuum. The manner in which we have used an adaptation of the classic Fechnerian Method of Paired Comparisons for this purpose and some of the issues encountered in implementing this purpose in regard to such problems as batch size and batch comparability have already been stated elsewhere (Luborsky and Sargent, 1956; Wallerstein and Robbins, 1960) and will be the subject of extended discussion in a forthcoming publication

¹⁰ In part, these judgements do link, of course, to 'behavioural' cues; in part, however, they are functions of the organization of those cues in terms of the theoretical framework within which their meanings are assessed. The fuller exposition of issues confronted in this anchoring

our entire research enterprise to clinical judgements as our essential data, without trying to trace each such judgement (insofar as one can) to cues in behaviour, is given by one of our group (Sargent) elsewhere (Sargent, 1961).

by Sargent on the quantitative aspects of the project.

Conceived this way, measurement, in the sense of quantification (along a rating scale for example), is not the touchstone of efforts to answer the crucial question of psychotherapy research—What does psychotherapy accomplish?—but rather one aspect of a complex task of assessment and judgement, in which whatever degree of precision and number use is incorporated as the problem and the data allow. Ideally, statistical manipulations that are appropriate to the (clinical) problems and data can simplify and extend the conceptualization of the phenomena under study by pointing to suggestive clinical and theoretical relationships to be further investigated and ultimately to be qualitatively explicated—again, by clinical judgements within a theoretical framework.

In these terms, we have tried to make clear the rationale for our concentration on the twin questions: (1) *What* changes have taken place in what variables relevant to intrapersonal and interpersonal functioning?—the outcome question—and (2) *How* have those changes come about or been brought about?—the process question—as the key empirical questions in the field of psychotherapy research. We have elsewhere discussed (1) the ways in which we have tried to bring the concept of scientific controls into relation to these questions, so that our answers to them do not become the products of circular reasoning within a closed system (Robbins and Wallerstein, 1959); and (2) the kinds of operational problems encountered in implementing a clinical research design geared to these questions (Wallerstein and Robbins, 1960; Hall and Wallerstein, 1960).

We have not, to this point, come back directly to the value question of whether the overall changes that are thus discerned, intercorrelated, and explained represent improvement for any individual patient, and if so, in what terms. Yet

it is improvement out of a state of ill-health or dissatisfaction with himself, that the patient comes initially seeking. We cannot avoid the fact, as already stated, that psychotherapy is always a valiative procedure, explicitly in the patient's eyes and, more than we usually acknowledge, in the therapist's eyes as well. It is in value terms that the patient judges his experience in psychotherapy ('Have I been helped?') and in value terms that the social support for psychotherapy research is predicated ('Does it help, and if so, how much?').

This judgement as to the extent of 'improvement' is thus one that in the end cannot be sidestepped. For purposes of scientific investigation into the nature of change brought about by psychotherapy, we have chosen to concentrate our major research effort on those empirical propositions that promise to extend the boundaries of established knowledge about what makes for change in therapy and thus to help build a more comprehensive and clinically useful psycho-analytic theory of therapy. At the same time, for purposes of attempting answers to those value propositions that govern the interest of patient and public alike in psychotherapy research, we, as one of our final steps, after the individual assessment of all the interacting variables in each of the three major groupings at each point in time, make a valiative judgement of the patient's position on a Hundred-point Health-Sickness Rating Scale.¹¹

We use the position on this scale, the value judgement about the patient's degree of mental health and illness as one additional variable, to be studied in interaction with all the other variables, so that ultimately we shall be in a better position to judge values comparatively and realistically, in the same way as each other aspect of psychologic functioning under scrutiny. Though we thus include, as part of our research study of each case, at each point in time, a statement of position on a scale of health and sickness

¹¹ This scale was constructed to represent an overall judgement, in keeping with a global conception of the concept of health. It is, however, a composite, arrived at by consensus of ratings along seven sub-scales which together embody those value judgements that underlie our agreed-upon thinking about the criteria for mental health. These seven (each of which can be rated on a 100-point scale) are:

- (1) The patient's need to be protected and/or supported by the therapist or hospital v. the ability to function autonomously.
- (2) The seriousness of the symptoms (e.g. the degree to which they reflect personality disorganization).
- (3) The degree of the patient's subjective discomfort and distress.

- (4) The patient's effect on his environment: danger, discomfort, etc.
 - (5) The degree to which he can utilize his abilities, especially in work.
 - (6) The quality of his interpersonal relationships (warmth, intimacy, genuineness, closeness, distortion of perception of relationship, impulse control in relationships).
 - (7) The breadth and depth of his interests.
- An account of the problems encountered in the development of this scale, as well as reports of the pilot trials and initial reliability studies, is being separately published by one of our group elsewhere (Luborsky, 1962).

that essays to measure improvement in value-determined terms, we see this statement as an assessment of but one variable among many. As scientists, we see our task as an inquiry into the

empirical problems of the nature of the psychotherapeutic process through the assessment of changes and the interrelations of changes among all the selected variables.

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THE PLACE OF NEUTRAL THERAPIST-RESPONSES IN PSYCHOTHERAPY WITH THE SCHIZOPHRENIC PATIENT¹

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I. Introduction

In this paper I shall first detail the results of various sensory-deprivation experiments, as reported in the literature, and shall then compare the experience of the normal subject in these experiments with the experience of the person who is suffering from chronic schizophrenia. Next I shall show that although there are many similarities between schizophrenic experience on the one hand, and sensory-deprivation experience on the other hand, this does *not* mean that the therapist in working with the schizophrenic patient should endeavour, consistently and vigorously, to provide him with abundant sensory experiences—by being, for example, consistently 'active' and emotionally responsive to him—for, as I shall attempt to demonstrate, the patient's subjective sensory-deprivation has a *defensive* function, and it therefore will be meeting one of the patient's real emotional needs if the therapist, while being in general more emotionally responsive than he generally is with the neurotic patient, will none the less supply the patient, not infrequently, with emotionally *neutral* responses.

I wish to emphasize that this paper is not an attempt to prescribe to my fellow-therapists how they *should* react in working with the schizophrenic patient; it is an attempt, rather, to help them to become freer, as I have gradually by dint of hard struggle become freer, to react in the ways in which the psychotherapeutic process, between therapist and schizophrenic patient, *inherently tends to require* the therapist to become free to react, as that process unfolds. It is often hardest of all for us to allow ourselves to react in an 'unfeeling' way, and it is with that particular sector of the therapist's overall feeling-participa-

tion, in the treatment of schizophrenia, that this paper deals.

II. The Relevance of the Sensory-Deprivation Experiments to Schizophrenia

The extent to which the schizophrenic individual is living in a state of sensory deprivation, and the implications for psychotherapeutic technique which arise from this state of affairs, began to interest me three years ago, in the course of my work with a schizophrenic man who, despite a demeanour of moderately good contact with outer reality, recurrently surprised me with indirect revelations of the profound degree to which he was suffering from a state of sensory deprivation. Thus alerted, I subsequently came to perceive a previously unsuspected intensity of sensory deprivation in the subjective experience of various other schizophrenic patients.

For many years there have appeared random reports of observations by explorers, shipwrecked sailors, aviators, prisoners in solitary confinement, mystics, and philosophers concerning the marked changes in personality functioning which arise in these various situations of marked isolation with attendant deprivation in terms of sensory stimuli from the outer world. But only during the last decade and a half, with the increasing number of studies of experimentally-induced sensory deprivation pioneered by Hebb (1937A, B, 1949), have such random reports in the general literature become the focus of our specific interest, and have the effects of sensory deprivation been studied systematically.² These effects include, in so-called normal subjects, many transient changes of the kind more durably evidenced in persons suffering from schizophrenia—deterioration in ability to think and

¹ This research was supported by a grant from the Ford Foundation to the Chestnut Lodge Research Institute. Abbreviated versions of this paper were presented at the 5 December, 1961 meeting of the Association for Psychoanalytic Medicine, and the 8 December, 1962 meeting of the American Psychoanalytic Association, both in New York City.

² Miller (1962) has provided a splendidly comprehensive bibliography both of relevant writings in the general literature and of relevant studies and conceptual formulations in the scientific literature.

reason, perceptual distortions, gross disturbances in feeling states, and occurrence of vivid imagery, sometimes in the form of bizarre hallucinations and delusions.

The experimental techniques of reducing environmental input have included (a) absolute reduction of sensory stimulation, as in the experiments of Lilly (1956) and Camberari (1958), whose subjects were immersed in a water tank, nude except for a blacked-out face mask through which they breathed; (b) reduced patterning of sensory input, as in the work of Bexton, Heron, and Scott (1954), in which translucent goggles permitted light but no patterned vision, patterned sound was also minimized, and kinesthetic and tactile stimuli were interfered with by the use of cardboard cuffs and gloves; and (c) imposed structuring or monotony of sensory environment without reduction of stimulation, as in the experiments of Kubzansky and Leiderman (1961), who utilized a tank-type respirator with the vents open so that the subject breathed for himself, while vision was normal but restricted to a very limited field, and auditory and tactile-kinesthetic cues were dealt with as in the second technique, thus structuring sensory inputs in a monotonous, unchanging way.

The schizophrenic patient is often living in an environment which is, to the observer's view, deceptively rich in providing sensory stimulation, at least as contrasted to such experimental situations as those just outlined. But the hypnotic situation, helpfully included by Rapaport (1958) in his review of the various situations which are characterized by sensory deprivation, provides a particularly meaningful analogy to the experience of the schizophrenic patient in this regard: there may be no lack of environmental stimuli physically within reach of the hypnotic subject, yet for psychological reasons he is effectively cut off from them.

The relevance of sensory-deprivation experimental findings to clinical work with schizophrenic patients, no doubt already widely apparent to clinicians, was explicitly discussed by Rosenzweig (1959), and I noted (Searles, 1960, p. 166) that the impoverishment of the perceived world for some adult schizophrenic individuals approximates to that of the subject in these isolation experiments. Stanley Cobb (1961), in his introduction to the largely laboratory-oriented symposium entitled *Sensory Deprivation*, suggests that 'the symptoms of the deprived child with "atypical" and "autistic" reactions

are without doubt related to the phenomena seen in adults after experimental sensory deprivation.' Pious (1961), in a careful clinical study of a schizophrenic patient's progressive changes in behaviour and inner experience, says, 'I have defined the precipitating circumstances [i.e. of the patient's moments of loss of psychological contact with the therapist] as psychological deprivation. This suggests a connection with such current ideas as sensory deprivation, sleep deprivation, etc., and I have a hunch that there may very well be such a connection.' Arieti (1961b), after commenting upon the sensory deprivation experiments, notes that 'In schizophrenia too we have some kind of psychological isolation. . . .'

I find certain of the data from these experiments to be particularly suggestive. The reported disturbances in body image in some subjects are identical with those which I have found in some of my most deeply disturbed patients, and which, with the exception of reports of LSD-induced psychoses, one rarely sees reported; Freedman *et al.* (1961), for example, mention that to four of their subjects 'the arms seemed to be dissociated from the body; the body seemed to become smaller; there was a sensation of floating in the air; the body seemed to become rigid and could not move'; and Cohen *et al.* (1961) report that one of their subjects 'became unsure of his body position and feared that his body parts would disappear and disintegrate.' Vernon *et al.* (1961) report that under the conditions of sensory deprivation the skin resistance goes down, and express their belief that sensory deprivation generates a great need for socialization and physical stimulation; one is impressed with the relevancy of their findings to the well-known clinical observations of schizophrenic patients' intense hunger for, and equally frequently-seen dread of, physical contact.

Riesen's (1961) finding, in both cats and apes, that 'Stimulation that would be ordinary for the species in nature or in the laboratory can, at the end of sensory deprivation, produce paroxysmal fear' has helped me to understand better some of the intense startle-reactions among my patients, as being due to their having suddenly become aware of my presence after having been experiencing—unbeknown to me at the time—a period of sensory deprivation during which, although their eyes may have been upon me, they had been, I subsequently realized, unaware of my presence. One has a new appre-

ciation of the long-known empirical finding that the patient in tenuous contact with reality reacts badly to sudden physical movements on the part of the therapist.

Finally, the 'white noise' (a random mixture of all frequencies), which Freedman *et al.* (1961) report to be extraordinarily effective in evoking the phenomena of sensory deprivation, seems to me to have a strikingly close analogy in the experience of the severely fragmented and dedifferentiated schizophrenic individual, whose subjective experience is, as best one can determine, a comparably discoordinate welter of fragmentary sensory-impressions, fantasies, memories, and so on. In this connection I find of interest Pious' (1961) impression that 'there is no diminution of the quantity of sensory intake in schizophrenic behaviour no matter how it may be restructured at any level', a view comparable with Rosenzweig's (1959) earlier-stated hypothesis that 'The critical factor in schizophrenia is . . . the inability to establish the relevance of sensory experience for ongoing processes.'

The severity of the sensory deprivation suffered by chronically schizophrenic patients has recurrently surprised me; I refer, here, not to the patient who is obviously so 'out of contact' as to be manifestly living in a predominantly hallucinatory world, but rather to patients who seemingly possess a fair measure of reality-contact. One such woman let me know that, in her more disturbed periods, she was unable to perceive the heads of other persons, including myself, because of a 'vapour' which concealed them. On many occasions she let me know, always indirectly and with much apprehension, that she was at the moment quite unable to perceive me, and was perceiving instead, in my place, her daughter or her son, or a sister, or a death's head, or various other human or non-human forms. On one occasion she let me know that during various of our sessions, she saw in me her children, for example, more clearly than she could perceive them during the actual visits which she had with them on infrequent occasions. A man confided to me that he felt himself to be 'in a mist', and another woman repeatedly made as if to run through me, as though unsure that I existed. She was reminiscent of the 10-year-old boy described by Bonnard (1958) in 'Pre-Body-Ego Types of (Pathological) Mental Functioning', of whom she writes, '. . . his 2-year-old brother was repeatedly walked through and over, as if non-existent'. There

was a period of some months during which I feared that this woman would seriously injure herself by hurling herself into the walls of her room, and I am now convinced that this was not on the basis of a conscious suicidal urge, but rather the expression of a need to make contact with an outer reality the existence of which she could not surely perceive visually, auditorially, or even tactually. Even this very ill woman only rarely and indirectly divulged the extent of the sensory deprivation in which she chronically lived; patients feel as ashamed, humiliated, and apprehensive about revealing this aspect of their experience as they do about revealing the fact that they suffer from hallucinations.

The schizophrenic individual suffers from sensory deprivation to a far greater degree than does the normal subject who is merely exposed, as in the sensory deprivation experiments, to external surroundings which provide minimal sensory input, for the former has to a large degree lost his *inner world* also; unlike the normal subject, he cannot turn to an inexhaustible and well-integrated inner world of fantasy to provide him with 'sensory data' of a sort, and thereby fill the void in his sensory experience.

One hebephrenic woman, for example, asked me, 'Are there any stores?', in such a way as forcefully to convey to me her experience of the world as one so desolate that there may exist no stores anywhere in it. Later in the same hour, after much fragmentary talk, she made mention of a particular hospital (the one to which she had been taken when she had initially become psychotic) and a particular store (where, whether during that same era or not, she had evidently gone to buy phonograph records), and she made quite clear to me that, in her subjective experience, these were the only two places in the world as she could presently conceive it; all this reminded me very much of how the world might look after nuclear warfare, with only a few scattered places left standing. A man described his total experience as a candle flame that kept flickering down and going out, and a woman dreamed of herself as a bombed-out building. Van der Heide (1961), in his paper entitled 'Blank Silence and the Dream Screen', describes, from his work with a woman suffering from a severe ego disorder, her loss of an internalized mother image as manifested by her dream of the caving in of a house near an ocean. This is a sample of the dedifferentiation which affects the inner, as well as the outer, experiential world of the schizophrenic person. It has required

years of intensive psychotherapy, in the instances of some of my patients, for them to be able to achieve any fantasy-life whatever, differentiated by them as such, in contrast to their erstwhile immersion in a chaotically dedifferentiated amalgam of experience in which memories, fantasies, somatic sensations, and perceptions of the outer world had not been separable from one another.

The mechanism of unconscious *denial* accounts, of course, for much of the patient's sensory deprivation; when, for example, one endeavours to convey to him some communication which runs counter to his superego, he may show an astonishingly concrete adherence to the principle of 'speak no evil—hear no evil—see no evil': one is left feeling not consciously ignored, but literally unheard. Of interest in this connection are Warren M. Brodey's (1959) observations, from his studies of the interaction of schizophrenic patients with their families, vividly portraying that, in the upbringing of the child who later develops schizophrenia, only those ingredients of what we call outer reality which are significantly supportive of, or significantly threatening to, the mother's 'inner workings' comprise the effective outer reality of the child; evidently the remainder of outer reality, for all practical purposes, simply does not exist for him.

But important though unconscious denial is—and I shall give a number of additional instances of it—the already-mentioned defence mechanism of dedifferentiation is, I think, equally important in giving rise to sensory-deprivation phenomena.³ Many writers have described a loss of ego-boundaries as being among the fundamental characteristics of schizophrenia; this symptom involves, by definition, the patient's relating symbiotically to the persons in his environment, as well as his inability, similarly, to distinguish clearly between himself and the non-human ingredients of his surroundings (Searles, 1960). My point here is that to the degree that such symbiotic or 'oneness' experience of the world prevails, the patient is not provided with any subjective experience of sensory input from an outside world, for he has no outer world, experienced as such. Martin Buber (1957) has pointed out that 'entering into relationship' presupposes a 'primal setting at a distance'. One could say that to the degree that the unconscious defence of dedifferentiation has the schizo-

phrenic individual in its grip, he is unable to set anything of the potential outer world sufficiently at a distance to be able to experience it with his sense-organs. In my opinion, the state of 'psychological deprivation' which Pious (1961) describes as the most archaic level of behaviour in his schizophrenic patient, is a state in which the patient's experience has become dedifferentiated to a level of symbiotic relatedness with the therapist—a state in which the therapist does not exist for the patient, because in the patient's subjective experience the therapist is so much a part of him as not to exist in outer reality. Significantly, Pious mentions that 'The schizophrenic's "mental image" of the investigator seems to function to strengthen the threshold against psychological deprivation', and I gather that his patient lost that image at the moment, in the behavioural sequence, of what he calls the 'nadir event' of the psychological deprivation. Pious says that it 'is an event which seems to me to be completely enigmatic. . . . The insufficiency of the observations of this event stand in contrast to my estimate of its importance.'

I have seen much of what I believe to be this 'nadir event', or in my terms symbiotic relatedness, in my work with a hebephrenic woman who has been struggling for many months to achieve a separation between inner and outer worlds. In one hour, for example, she said roughly, in a tone as though she wished I would disappear, 'Why don't you be a piece of cake and eat it?' Then, following several minutes of comments which I found unintelligible, she said, 'Then you'd have your cake and eat it— . . .', and after another several minutes' interlude of comments which I again found undecipherable, she asked, 'Did you ever have a piece of cake there and then it *wasn't* there?' This was said in a tone clearly implying that this is what happens, or has happened, in her experience, and she looked reproachfully and accusingly at me as she asked this. Data from subsequent hours, too detailed to reproduce here, indicated that the cake symbolized (among, no doubt, other meanings) myself, whom she recurrently 'ate' and disgorged, in varying states of, respectively, symbiosis and object-relatedness in the transference. In another hour, her wish for us to have hamburgers revealed itself as her wish for us to eat one another; and in still another hour a lollypop which she kept trying to push down her throat and make it stay

³ I hope it is clear that I am using the term 'sensory deprivation' here in a phenomenological sense only, as a means of attempting to describe some aspects of the patient's experience, rather than putting forward 'sensory

deprivation' as a separate and special psychodynamic defence mechanism, on a par with such mechanisms as denial and dedifferentiation.

down inside her represented, for her, her therapist who kept leaving her.

Concerning normal subjects' reactions to experimental sensory deprivation, Freedman *et al.* (1961) advance the hypothesis that 'it is the absence of order or meaning rather than the specific nature of the stimulus field which tends to degrade perceptual organization', and suggest that 'The auditory and visual "hallucinations" . . . may be thought of as the result of an attempt to order such stimuli as are available because of the need to find meaning in the environment.' Similarly, Ruff *et al.* (1961) state, in the conclusion of their report of their studies, 'Our formulation . . . is that isolation "destructures" the environment. The subject responds by restructuring to create a sense of continuity with his previous existence. He thus restores meaning to the situation.' This is in interesting contrast, but certainly not contradiction, to an hypothesis I put forward in 1960, namely that the schizophrenic patient's unconscious denial of outer reality has a restitutive aspect, in that it provides him with a more or less blank screen upon which a necessary reprojected of pathogenic introjects, an externalization of internal conflicts from the past, can now be effected—akin to the function of the neutral screen atmosphere fostered by the analyst in the treatment of the neurotic individual (Searles, 1960, p. 167).

One can think of it that such a 'neutral-screen' perception of his outer world permits the schizophrenic individual to utilize, as a necessary defence against overwhelming affects, the kind of primitive denial of which Jacobson (1957) writes, when she says, ' . . . clinical observations leave no doubt that denial is a more archaic, more primitive, and historically earlier mechanism than repression—in fact, its forerunner . . . denial presupposes an infantile concretization of psychic reality, which permits persons who employ this defence to treat their psychic strivings as if they were concrete objects perceived.' A person who possesses a normal clarity of perception of the actual concrete objects in his environment is thereby barred from utilizing such a defence; to use it, outer reality needs to be one's own mass of plasticine. Of etiological interest, here again, are Warren Brodey's (1961) observations. Emphasizing the importance of the mechanism of externalization, which he defines as projection plus the selective use of reality for verification of the projection, he reports that 'This selective use of reality was extreme in all the families observed. . . . Each

family member appears to cathect with interest and meaningfulness only a limited aspect of his environmental surroundings—that which validates expectation; the remainder of the reality available for perception is omitted.'

Dement's (1960) dream-deprivation experiments, the results of which suggest that a relatively generous opportunity to dream is essential to healthy psychological integration, even for the normal individual, are relevant here. So, too, is Macalpine's (1950) paper, 'The Development of the Transference', in which she points out that transference—the development and evolution of which is so essential to psycho-analytic cure—does not simply arise spontaneously in the patient in the psycho-analytic setting, but that, rather, 'Psychoanalytic technique creates an infantile setting, of which the "neutrality" of the analyst is but one feature among others. To this infantile setting the analysand—if he is analysable—has to adapt, albeit by regression. In their aggregate, these factors, which go to constitute this infantile setting, amount to a reduction of the analysand's object world and denial of object relations in the analytic room.' Gill (1954) expresses his concurrence with Macalpine's view in this matter and expresses his own conviction that 'The [psycho-analytic] technique itself exerts a nonspecific, steady, unremitting regressive pressure.' It is of further interest that, in Macalpine's list of fourteen ingredients of the analytic situation which so formidably foster the development of transference on the part of the patient, heading the list are, '1. *Curtailment of the object world.* . . . External stimuli are reduced to a minimum. . . . and '2. *The constancy of environment*, which stimulates fantasy.'

Sechehaye (1956, pp. 109–110) comments that one function of a psychosis consists in 'scotomizing all sectors of reality related to the frustrations. . . . For this reason, Renée came to believe that the world did not exist and that she herself was only a shadow.' This observation reminded me that one schizophrenic woman's functional environment, about the hospital grounds, proved to be a complexly restricted one, interlaced with forbidden areas which were effectually barred from her existence, because for her to enter into these *geographical areas* would involve her being assailed with the repressed emotions—of, most prominently, grief—which were related, by associational memories, to the various corresponding areas of her past life; by living in a thus restricted environment, she

preserved her protective areas of amnesia. Similarly, I realized that when a hebephrenic woman walked about the floor of her room, near me, in a highly complex pattern, for all the world as if walking on steel beams set about yawning gulfs at her feet, this intricate pattern corresponded to her anxious avoidance of innumerable feeling-laden topics in our therapeutic investigation; but I do not doubt that she genuinely experienced this, instead, in the form of the multiple mouths of an abyss at her feet, such that she must not stray off the narrow and complex path along which she was teetering.

With a somewhat less deeply ill woman I was able to delineate, piecemeal but quite specifically, various of the affects which one of her former denial-symptoms had served to keep repressed. She described her never having seen any men during her trips from her suburban parental home into Philadelphia. It developed that this scotoma had at least the following determinants in various different areas of her unconscious: (a) her parents had ingrained in her the deep-seated conviction that it is immoral for a young woman to 'see men'; (b) she was so fully, though at a deeply-denied level, absorbed in unworked-through feelings of loss of various girls and women she had known in the past, that men did not exist for her; (c) she was afraid, at another unconscious level, that if a man's face registered in her perception, she would lose control of her rage-toward-men and hit him on the jaw (for, as she felt it, robbing her of her feminine friends); and (d) the sight of a man's face would bring before her, also, the unresolved grief over the death of a young male cousin whom she had loved.

III. *The Important Role of Neutral Therapist-Responses in the Psychotherapy of Schizophrenia*

All that I have been saying here has implications concerning the schizophrenic patient's need for a readily available neutral response from his therapist.

Many of the writings in recent years concerning the psychotherapy of schizophrenia, including my own, have emphasized that the therapist must be able to provide in generous measure an intensity of emotional response which goes far beyond Freud's (1912) injunction to the analyst: 'The doctor should be opaque to his patients and, like a mirror, should show them nothing but what is shown to him.' Sechehaye (1961), noting that even in the analysis of the neurotic patient the analyst must at times 'depart from his

absolute neutrality and from his role of the reflecting mirror', emphasizes the psychotic patient's need for personal involvement. Perry (1961) says that, in the psychotherapy of schizophrenia, 'the ideal situation would be one in which the patient feels that anything he reveals is found meaningful by the therapist, who then responds to it with genuine resonance'. Arieti (1961A), in setting out to list the necessary components of the 'therapeutic attitude' for work with schizophrenic patients, emphasizes, 'First, the therapist must have an attitude of *active and intense intervention*. He comes to participate in the struggle which goes on and not to listen passively to ideas which cannot be associated fully.' Jackson's (1961) scorn for the neutral response is apparent in his following comment, concerning the historical development of this area of psychotherapy: 'Perhaps because the therapist had a mother himself he could identify with the almost unverbalizable horrors that stemmed from the schizophrenic's longing, despair, and hate. When a therapist became a part of these feelings he was more able to become aware of his own responses, since it was unlikely that any mortal could sit inscrutable amidst these emotional barrages.'

But I wish to emphasize here that, although it may indeed severely threaten our sense of humanness, the schizophrenic patient needs from us not only the kind of intense emotional responsiveness which makes for comparatively dramatic clinical papers, but an equally liberal measure of neutral, and related, responses: responses of inscrutability, imperturbability, impassivity and, on many occasions, what can only be called indifference.

Only by a comparatively unanxious acceptance of such responses, or such lack of response, in ourselves can we help the patient to erode through the areas of 'as if' pseudo-emotion, ostensibly intense emotion which is not truly an indication of deep inner experience but rather a superficial imitative phenomenon, which has been described by Helene Deutsch (1942), Annie Reich (1953), Kurt Eissler (1953), and Greenson (1958) in patients with ego-disorders of various degrees of severity, and which I have found to be very prominent, indeed, in deeply and chronically schizophrenic persons.

Early in my work with a hebephrenic woman --to give but one typical example--I at times felt troubled, and doubtful of my capacity for human feeling, at finding myself utterly unmoved to sympathy despite her being apparently in the

grip of intense and wordless grief: her body was convulsed and wracked by sobs, her face appeared ravaged by grief, and she showed a little child's helplessness to cope with the tears which streamed copiously down her cheeks. Only after many months did it become clear that such behaviour arose from introjects of her mother and her maternal grandmother, with whose controllingness-through-weeping the girl had never been sufficiently 'hard' to cope successfully.

On other occasions in the early months of the therapy, she showed a seductive woman-of-the-world demeanour to which I fell to reciprocating, at the level of a kind of mutually 'knowing' repartee filled with sexual allusions. In the course of several weeks she became increasingly anxious in this setting, finally cowering away from me, at the opposite side of her room, and calling out desperately, like a little girl who had got into water well above her head, 'You take the men, Mommy!'. This erotic kind of interaction, convincing though it had seemed as evidence of a well-established level of maturation, proved to be but a brittle kind of 'as-if' defence against her deeper and more genuine infantile needs for mothering, which were to occupy as subsequently for years.

In one session which occurred after we had been working together for several years, she began imitating the various laughs of some six or eight student nurses who were playing and watching tennis on a court outside her window and who, on the eve of their return to their distant home-hospital after having completed their difficult psychiatric affiliation at Chestnut Lodge, were evidently filled with relief and exuberance. The silence of our session was punctuated only by her imitating, from time to time, one or another of the wide variety of laughs which came from the nurses. Her early laughs were done with such 'skill' that I thought her genuinely happy, found her laughs often infectious, and laughed with her. But then, as she went on laughing from time to time, the eeriness of what she was doing grew more and more upon me: it became increasingly clear to me that this woman was momentarily hiding her massive despair by imitating laughs for which she, unlike their original authors, had at the moment no correspondingly genuine wellspring of happiness; I hasten to emphasize that I had many times seen this woman in scattered moments of joy which I had found no reason to question. It was this particular session which

helped me to realize, in retrospect, how very much of this woman's behaviour over the years, including the period of her erotically-knowing, woman-of-the-world demeanour, had consisted in very complex, remarkably skilfully-woven fabrics of just such imitative behaviour of which she had been showing me, in this session, a few comparatively simple threads.

A neutral type of therapist participation proves to be essential to the resolution of the schizophrenic patient's basic ambivalence concerning individuation—his intense conflict, that is, between clinging to a hallucinatory, symbiotic mode of existence, in which he is his whole perceived world, or on the other hand relinquishing this mode of experience and committing himself to object-relatedness and individuality—to becoming, that is, a separate person in a world of other persons. Will (1961) points out that just as 'In the moves toward closeness the person finds the needed relatedness and identification with another; in the withdrawal (often marked by negativism) he finds the separateness which favors his feeling of being distinct and self-identified', and Burton (1961) says that 'In the treatment, the patient's desire for *privacy* is respected and no encroachment is made. The two conflicting needs war with each other and it is a serious mistake for the therapist to take sides too early.' The schizophrenic patient has not yet had the experience that commitment to object-relatedness still allows for separateness and privacy, and where Sechehaye (1956, p. 181) recommends that one 'make oneself a substitute for the autistic universe which alone offered some morbid satisfaction' to the patient, I find it more helpful to—primarily by my presence—offer myself as such a substitute; the choice must rest in the patient's hands. This I regard as the primeval area of applicability of a general comment by Burton (1961) that 'In the psychotherapy of every schizophrenic a point is reached where the patient must be confronted with his *choice* . . .', and of Shlien's (1961) comment that 'Freedom means the widest scope of choice and openness to experience. . . .'

IV. *The Ambivalence Concerning the Relinquishment of Autism-and-Symbiosis and the Acceptance of Object-Relatedness; Borderline States; Early Ego-Development in the Healthy Infant*

When the therapist conveys to the patient such a freedom to choose, he fosters by the same act an atmosphere in which the patient becomes exposed to a mounting inner necessity to choose,

a mounting realization of the necessity to commit himself to either an autistic-symbiotic mode of existence on the one hand, or on the other to genuine object-relatedness—to existence as a separate individual among individual other persons. This conflict is, I believe, beyond being of major importance in any instance of schizophrenia, of specifically central importance in borderline states; it is, in my experience, one conflict which quite precisely characterizes these latter states, which in other regards are so vague and difficult to describe.

The borderline patient is one who literally lives on the borderline between autism-and-symbiosis on the one hand, and object-relatedness on the other. It is as if he were trying to have the gratifications of both modes of relatedness, without relinquishing either mode; trying to work both sides of the street; trying, in an almost literal sense, to eat his cake (i.e. the other person, or whatever ingredient of the outside world) and have it too—to make it part of him, and yet simultaneously to make it available there in the outside world also. In actuality, he gets less than his share of either kind of gratification, and is far from feeling possessed of any conscious ability to manipulate these processes, however prone the therapist is to attribute such power to him.

The therapist in working with the borderline patient is often made to feel helpless in face of the seeming facility with which the patient, when faced with frustration during the course of genuine interpersonal-relating (as when the therapist is persistently and firmly putting forward an unpalatable interpretation) will shift into an inaccessible autistic state, or into symbiotic relatedness permeated by so much projection of part-aspects of himself upon the therapist, and so much of a regressive, concretist perception of the therapist's words that the latter suddenly finds his efforts at verbal, genuinely interpersonal relatedness to be totally ineffective. Similarly, the therapist finds that the patient is, for a long time, equally bafflingly and maddeningly defended against healthy symbiotic experience which the therapy must come to include, in order to be successful: the patient recurrently flees from the intimacy of any such developing oneness-experience into a defensive, and therefore unproductive, kind of object-relatedness which is only ostensibly mature.

Only in a therapeutic setting where he finds the freedom to experience both these modes of relatedness with one and the same person can

the patient become able to choose between psychosis and emotional maturity, and he can settle for this latter only in proportion as he realizes that both object-relatedness and symbiosis are essential ingredients of healthy human relatedness—that the choice between these modes amounts not to a once-and-for-all commitment, but that, rather, to enjoy the gratifications of human relatedness he must commit himself to either object-relatedness, or symbiotic relatedness, as the changing needs and possibilities of the human interaction require and permit.

I surmise that the basic therapeutic development which occurs in this setting is that the patient develops the ego-capacity to move, on his own initiative so to speak, from one mode of relatedness to the other. In contrast to the state of affairs one sees in the borderline patient, whose switches from one mode of relatedness to another are actually made in the face of a patient-ego more helpless than the therapist feels himself to be, and are dictated by the urgent need to avoid overwhelming anxiety, it is now a matter of there having developed, in the patient's ego, two powerful arms—one the arm of symbiosis, and the other the arm of object-relatedness—to meet and express a personal existence which is sensed as predominantly good and inviting rather than bad and anxiety-arousing.

Spitz (1957, p. 122) tells us that not until about the eighth month of life does the infant become able to discriminate between animate and inanimate in the surrounding world, and the adult schizophrenic patient shows us, in his rageful disapproval of any signs of aliveness in the therapist during this phase of ego-differentiation in the transference, how frustrating it is to the infant to recognize the mother's separate and inner-directed aliveness; the adult schizophrenic patient makes it quite clear that the therapist is supposed to be an inanimate instrument—a Coke machine, as one patient put it—which exists only for the automatic gratification of the patient's needs.

A hebephrenic woman clearly expressed the grief and feelings of rejection which are entailed in the resolution of the symbiosis with the mother-therapist—entailed in, that is, the recognition of an outside world in which the therapist exists. In one session, after I had recently relieved my intense frustration, arising from my long and arduous work with this deeply-fragmented woman, by expressing intense hatred and contempt towards her, I came up to her room feeling more than usually accepting of the difficult situation. She was lying in bed sucking her

thumb and looking confused and fragmented, as usual, when I came in, and after greeting her I sat down contentedly several feet from her bed and made myself comfortable. During the first few minutes she made a number of efforts at vocalization, but these were garbled and half-inaudible, and I said nothing until, after several minutes had elapsed, I asked in a semi-sardonic tone, 'How are things in your world?' She replied, 'I can't see much of it.' This was itself something of a revelation to me, although I had remembered her saying on an occasion several weeks before, while sucking her thumb, 'The harder I suck the more I can see.'

In saying, 'I can't see much of it', she was looking at one of the two bedposts at the foot of her bed, and she went on, 'Do you see anything wrong with that bedpost?' She agreed with my expressed hunch that it did not look like the other one, to her, and then her usual fragmentary comments contained repeated pleas to 'give me the key . . . the key to the bedpost'. She then glanced over at the fly of my trousers, and said, 'She wants to see it—do you know what I mean?' She often referred to herself in the third person. I replied, 'It *sounds* to me as though maybe she wants to see my penis.' She clearly rejected this comment, saying, 'She wants to see the outside world. Some people do', she added with a bereft expression on her face. I replied, 'You don't see much of the outside world, I guess, do you?—And you'd like to be able to see more of it.' She responded harshly, antagonistically, and scornfully, 'I don't *care* about the outside world! I care about the *inside*!', and then during the next few moments she was looking rejected and making brief comments conveying her rejected feeling. I said then, kindly and firmly, 'Now you get feeling rejected; you very quickly get feeling rejected, don't you?' She replied, feelingly, 'It's hell, isn't it?'

At another point in the hour she was looking over at my shirt, and said, with love and grief in her voice, 'That's a nice shirt . . . I like to sit and look at the shirt.' It was as if her rare and cherished seeing of my shirt was itself a realization of our separateness from one another. Soon after this she asked, 'Do you know what my mother feels?', in a tone as if she were asking, 'Do you know whether she feels anything?', and went on, 'Do you know what she feels about sitting?' On an earlier occasion, she had said, after one of her mother's hurried and hectically gay visits to the Lodge, 'I've seen the flight of the bumble-bee'. Her own introject of this incessantly active, superficially gay but inwardly despairing and unrelated, mother had required years of therapy, earlier, to resolve. She now went on, about her own head, saying that she guessed that it 'needs a lot of fixing', and later commented, 'I should have sat!', agreeing that she thought this might have prevented the trouble with her head.

In my monograph concerning the non-human

environment (Searles, 1960) I included many separate instances of the schizophrenic patient's reacting to the therapist as being an inanimate object. Since then, I have come to see what I feel to be a more adequate total picture of the process of psychotherapy with the schizophrenic or borderline schizophrenic patient, as a process in which there is first a gradual dedifferentiation of the patient's confusingly complex but 'autistic' experience, into a phase analogous to the dream screen described by Lewin (1946, 1953) a phase of relative blankness as far as content is concerned by reason of the deeply-undifferentiated symbiosis with the therapist. It is, I have come to see, in this phase that the whole of the patient's former 'reality', including the whole non-human realm in aggregate, is as it were poured into the symbiosis with the therapist, and it is out of this symbiosis that the patient's 'reality' becomes more deeply cathected with feeling and, therefore, a genuine sense of reality, and he correspondingly becomes more deeply able to distinguish among such realms as human and non-human, animate and inanimate, through rediscovering them in the therapist-mother. In a sense, the therapist mediates the re-creation of the patient's 'world in a way that at moments can only be felt as godlike; but a new world is created for the therapist, too, out of such deeply symbiotic experience. One experiences, in the symbiotic phase of this mother-infant transference, the validity of Sechehaye's (1956, pp. 58, 165) comments, concerning the child's relationship with the mother, 'Does not the child . . . through her establish his early relations with the outside world? . . . In a way, the mother is the child's first ego . . .' and, ' . . . to the small child, is his mother not the whole universe? When the first object relations develop amid insecurity and aggression, the individual never succeeds in creating stable and positive relationships with the world around him . . .', and the validity of Spitz's (quoted Sechehaye, 1956, p. 58) terse comment, 'The nursling's ego is his mother's ego.'

Rycroft (1951) reports that, in analysis, 'the occurrence of a blank dream marks . . . a turning point, namely, from a narcissistic state toward a recathexis of the external world and a thrust in ego development', and Van der Heide (1961) while regarding his borderline patient's transitory blank silences as defensive in nature and, in one instance, describing it that 'the very matrix of transference, the early mother-infant relation of the preverbal stage, became exposed' as a result

of an interpretation which 'shattered the actual ego-defences and a functional ego regression took place', none the less indicates cautiously that these blank silences were, as in the instance of Rycroft's experience, followed by clinical improvement. Although I cannot approve of the technique of Azima, Vispo, and Azima (1961), who promote the patient's regression to a state of infantile dedifferentiation through exposing him to an experimental-type situation of sensory deprivation, I am convinced, as I have mentioned in earlier papers (1959A, B, 1961), that a naturally-occurring, and to a significant degree mutual, phase of symbiotic relatedness in the transference, holding sway not for merely moments but for months, is the core phase in the psychotherapy of schizophrenia. A form of neutral participation by the therapist is essential to the development, and successful traversing, of this phase; too much activity from him, whether verbal or non-verbal, interferes with and may thwart this evolution.

V. The Therapist's Face

The therapist's face has a central role in this symbiotic interaction. In each of several instances in which deeply and chronically schizophrenic patients have progressed far towards recovery in my work with them, the symbiotic phase has been characterized by, among other manifestations, his or her sitting and staring at my face, in session after session, with all the absorbed wonderment, and responsive play of facial expressions, of a child immersed in watching a fascinating motion picture. I can now fully believe Spitz's (1945) comment that 'The child . . . learns to distinguish animate objects from inanimate ones by the spectacle provided by his mother's face in situations fraught with emotional satisfaction.' It is thus, in fact, that the child—or the adult schizophrenic patient—becomes aware of his own limitlessly varied emotional capacities, and even of his very aliveness, seen first as attributes of the mother-therapist. Freud (1923), in *The Ego and the Id*, stated that 'anything arising from within (apart from feelings) that seeks to become conscious must try to transform itself into external perceptions . . .'; from what we now know of normal infants and of adults recovering from schizophrenia, we can include feelings also within that principle. The deep significance of the face is emphasized in another statement by Spitz (1957, pp. 127–128): 'The inception of the functioning of the reality principle is evident at the three-months level,

when the hungry infant becomes able to suspend the urge for the immediate gratification of his oral need. He does so for the time necessary to perceive the mother's face and to react to it. This is the developmental step in which the "I" is differentiated from the "non-I"; in which the infant becomes aware of the "otherness" of the surround.'

Papers by Greenacre (1958), Almansì (1960), and Elksich (1957) have served to highlight further the significant role of the face in early ego-development and in the establishment and maintenance of object-relatedness. Greenacre (1958), in her paper entitled, 'Early Physical Determinants in the Development of the Sense of Identity', states that

'The body areas which are . . . most significant in comparing and contrasting and establishing individual recognition of the body self, and that of others, are the face and the *genitals*. While some response to the mother's or nurse's face occurs very early, there can be no comparison of this with the own face until relatively late. . . . They are obviously of basic importance in the sense of identity. At the same time they are the areas which are least easily visible to the individual himself. As no one ever sees his own face, the nearest he approaches this is the reflection of his face in the water or a mirror. . . .

' . . . It would appear that even at a mature age the individual is in need of at least one other person, similar to himself, to look at and speak to, in order to feel safe in his own identity, i.e. that there is a continual reinforcement of the sense of the own self by the "taking in" of a similar person without which an isolated individual feels first an intensification and then a diminution of the sense of self and of identity. . . .

Almansì (1960), in his paper entitled 'The Face-Breast Equation', refers to Spitz's (1955) (a) postulation that, from a visual standpoint, the Isakower phenomenon and Lewin's dream screen do not represent the breast but rather the visually perceived human face; (b) observation that the nursing infant's gaze is constantly fixed on the mother's face; and (c) studies on the importance of the infant's recognition of the Gestalt of the human face first, and later identification of the mother's face, in the development of object relations and in the early mental life of the child. Almansì offers clinical evidence in support of his own speculation that the fusion of these two percepts (i.e. the percept of the breast and the percept of the face), the screening of one by the other, and their equation may occur more frequently than we have realized. Of especial interest is his presentation of evidence, from

various cases, that the percept of the face has been even more deeply repressed than the percept of the breast. He writes,

'... clinical experience indicates unequivocally that on a primitive perceptual level the face may be equated with the breasts, and that there is a particularly strong correlation between the nipples and the eyes. ... It is also apparent that this phenomenon is not rare, as I have noted its occurrence in four patients, and shortly thereafter three other cases were called to my attention. The delineation of this [face-breast] equation confirms Spitz's hypothesis, i.e. that under conditions of deep regression the percept of the face may re-emerge from its condensation with the breast image, which may be said to act as a screen for the face. It is interesting to note that in this condensation it is the percept of the face which is most repressed and most strongly cathected.'

Elkisch (1957), in her paper 'The Psychological Significance of the Mirror', describes the significant role of mirrors in the symptomatology evidenced by three psychotic patients in her experience. Each of these patients, when faced with panic during or apart from his psychotherapeutic session, would rush to stare prolongedly at his face in a mirror, and one took to seizing frantically his therapist's hands and staring into her eyes in a similar manner. Elkisch follows Frazer (1947) and R  heim (1919) in emphasizing the connexion between mirroring and death:

'... This idea of death with regard to mirroring or reflecting one's image in the water is essentially connected with the idea of losing one's soul. "When the Motomuto of New Guinea first saw their likenesses in a looking-glass, they thought that their reflections were their souls." [Frazer (1947)] Man's mirrored image first must have appeared to him as something graspable, real. But since actually it was unreal, namely, not made of stuff he could lay his hand on, he obviously felt he was faced with his soul. And this soul being externalized might leave him and that would mean death. Contrariwise, the psychotic individual whose mortal fear of loss of self takes place inside of him seems to turn to the mirror as if it could protect him against such a loss. He "uses" the mirror in order to externalize, alias project, his impulses and conflicts (which in reality he denies). And since the act of projection means throwing on to someone or something outside what actually belongs inside, namely to oneself, such an act amounts to a loss of psychic content. Thus, metaphorically speaking, one could say that through projection a person "loses his soul".

'It has been my impression in the three cases cited that these patients tried to retrieve, as it were, in their

mirrored images what they felt they had lost or might lose: their ego, their self, their boundaries. ...'

Three schizophrenic women whom I have been treating for several years have shown a great deal of the kind of mirroring activity which Elkisch describes. My work with them and with other psychotic patients has suggested to me that the therapist (and, in particular, his face) comes to serve as a kind of mirror image to the patient—as, that is, an alter ego—preliminary to the patient's identifying with the increasingly emotionally-responsive therapist who confirms, by his increasingly rich responses, the patient's own re-differentiating emotional capacities. This is in line with a concept which I have presented earlier (Searles, 1959A, B), to the effect that, in the process of recovery of the severely fragmented and dedifferentiated schizophrenic patient, the growth-processes of integration and differentiation occur first external to the patient—in the realm of the therapist's developing responsiveness to him, and in the realm of the responsiveness to the patient which is engendered among the group of patients-and-personnel on his ward, and elsewhere—before the patient, by the process of identification with the increasingly richly integrated responsiveness of these others, makes the advancing growth process an integral part of himself.

Where Elkisch describes the psychotic patient's use of the mirror as representing his panicky endeavour to cling to his identity, I think of this act as expressing *ambivalent* desires on his part, both to cling to *and to lose* (through externalization upon the mirror) his identity. The invaluable work of Erikson (1956, 1958) concerning identity-crises and other aspects of the struggle for identity has tended to highlight, by its very beauty and perceptiveness, the sense of ego-identity as something to be cherished, such that we tend to underestimate how ambivalent are one's feelings—particularly, the psychotic individual's feelings—about this matter of identity. Until comparatively late in his treatment, the psychotic person's precarious sense of ego-identity, is, I believe, predominantly negatively-toned; to be the person he feels himself to be means, more than anything else, to be a malevolent, lonely, and tortured outcast. It is small wonder that his anxiety lest he lose any sense of personal identity is balanced by his yearning to give up so painful an identity as this only one which he at all enduringly knows. Fromm's (1941) comments in his *Escape from*

Freedom, pointing out some of the psychological costs entailed in the development and maintenance of a sense of individuality, emphasize a facet of this subject of ego-identity not to be forgotten in our appreciation of Erikson's work which has had so great an impact upon our thinking in more recent years.

In these comments about the role, in therapy, of the therapist's face, I have been trying to describe something of the manner in which, in the evolution of the patient's transference to the mother-therapist, the patient becomes able to detect, and make increasingly part of himself, the whole realm of emotion which was too inaccessible hidden behind the inscrutable face of the actual mother of his infancy and early childhood, and which, consequently, has heretofore been walled off, within himself, to a comparably impenetrable degree, so that his own emotionality—an emotionality for these very reasons not yet at all well differentiated, not yet maturely elaborated—has been heretofore as inaccessible to him as was the realm of feeling in his mother. One hebephrenic woman repeatedly told me that she had never been able to 'meet' her mother, and for a long time reacted to me, in the transference-relationship, as a strange-mother who would not come forth to meet her. A paranoid woman described her sense of divorce from her own feelings as an experience of 'being completely severed from yourself'.

VI. Discussion

Sechehaye (1956, p. 186) beautifully describes it that the person suffering from schizophrenia 'needs time, time to learn to believe again in living, to renew his confidence in others; slowly to describe a silhouette, the therapist, which gradually detaches itself from chaos and takes form in his opaque, unstable, disorganized universe'. The therapist facilitates this best by silence; here is relevant a comment, from analytic work, by Arlow (1961): 'The magnificence of silence in interpersonal relationships is its very ambiguity.'

Emotions in the therapist have their crucial place in this work; but they cannot be, and need not be, forced. In the overall evolution of the transference-relationship, the therapist goes through, in actuality, a succession of very different 'neutral' orientations towards the patient. At first there prevails in him a kind of neutrality which is the manifestation of a lack of much feeling of any variety towards the predominantly narcissistically-oriented, rather

than object-related, patient. Later, his orientation shifts to a kind of neutrality towards the patient who is immersed now in object-relatedness, but of a deeply and pathologically ambivalent kind; the therapist sees and hears the patient's conscious and genuine efforts to make contact with him in a loving and constructive way, but is simultaneously equally aware of, and emotionally distanced by, the equally intense antagonism which the patient is as yet unaware of possessing and conveying. Still later, the therapist feels a kind of neutrality which is the manifestation of an unlimited multiplicity and variety of emotions. The patient now comes to see with fascination, in this phase of 'therapeutic symbiosis' (Searles, 1959A, B, 1961), the varied and changing feelings on the therapist's face not only through the mechanism of the patient's attributing his own re-differentiating emotions to the therapist, but also because the totality of the therapist's feeling-capacities have indeed been called into play, over the preceding months and years, in the development of this relationship which is so deeply significant to each of the two participants.

Seen retrospectively in terms of the above progression, the therapist's inscrutability is an externalized representation of the patient's limitless feeling-potentialities. As a therapist, just as I have found on innumerable occasions that an emotional response from me, of one kind or another, is vital to the patient's developing relatedness with me, I have seen equally often how a premature responsiveness on my part amounts to a kind of premature closure of a Gestalt in the patient-therapist relationship, with a consequent shutting off of an area of potential ego-development in the patient.

As a simple example of what I mean here, I came to see more and more clearly, through a series of incidents, that I was in effect acting out the rage which existed at an unconscious level in the hebephrenic woman I was treating; she seemed genuinely unaware of rage in herself, but through symptomatology which I found enraging would eventually promote such a degree of fury in myself that I could no longer contain myself. Most often, I would then explode verbally at her, but on one occasion hurled my cigarette lighter at her coat which, at the beginning of the session, she had deposited on my couch. After each such eruption on my part, the relationship would be, as it were, decompressed; her infuriating symptomatology would be decreased for a time. It became increasingly clear to me that the

moments when I would erupt would be junctures at which she was being increasingly hard put to it to avoid the recognition of her own fury, and that she would then 'succeed'—although not on the basis of any such conscious manipulation as this term might suggest—in getting me to express the anger for her, as it were. And now we come to the point I am attempting to illustrate here: it was only when I had come to see this process clearly, and when I had become able—only after two or three more such incidents, for my intellectual insight did not at once bring the necessary emotional capacity—to preserve, in the presence of my anger, a sufficient admixture of genuine objectivity, that I could as it were let her grow sufficiently to become aware of, and express, her own anger as such. This kind of development, this kind of acquisition of genuine neutrality and separateness on the part of the therapist, is crucial to the resolution of the therapeutic symbiosis and the patient's attainment, thereby, of ego-wholeness. My major theme in this paper is not intended to invalidate, but only to provide a necessary counterbalance for, the equally essential therapist-responsiveness, valuably stressed by many writers and advocated in particularly appealing terms by Perry (1961):

'The individuation process probably takes place only, or comes to fruition only, in relationship . . . when a patient in an acute turmoil is at some level trying to formulate a self-image, this stands in acute need of affirmation. . . . Such a self tends to take shape best in such a mutually animated emotional field. . . .'

I know of no simple answer to the question which emerges from this discussion: namely, *when* is it therapeutic for the therapist to respond neutrally, and when non-neutrally? This is a question which is always before the therapist, and which can only be decided from moment to moment on the basis of his intuitive—i.e. primarily preconscious and unconscious, unthought-out—sensing of the patient's changing needs. There are, I believe, broad fluctuations in the therapist's level of emotional responsiveness corresponding with broad phases in the overall course of the therapy. In a recent paper (Searles, 1961) I suggested that the earliest, or 'out-of-contact', phase of the treatment involves a less active feeling-responsiveness on the part of the therapist than do the subsequent phases of ambivalent and pre-ambivalent (therapeutic) symbiosis; and I implied that the next phase,

that of resolution of the symbiosis, and the final (essentially psycho-analytic) phase are characterized by, once again, a less overt feeling-responsiveness on his part, although his inner feeling experience is, of course, very different from that which obtained in him during the first phase of the treatment which I mentioned. Not only in such broad terms are there variations, but obviously also in any one session the therapist's necessary feeling-responsiveness may vary markedly, over a wide range, from moment to moment. I can offer no formula to apply to so changing and complex and living a situation, but have attempted here only to point up some of the dimensions of the patient-therapist interaction.

A man suffering from chronic paranoid schizophrenia with prominent depressive features became, in response to relatively active therapeutic responsiveness on my part, progressively silent and inactive, until eventually he was lying, for months on end, mute and motionless on his bed throughout our sessions. Nor was he more alive between sessions in the rest of his 'daily life' on the ward; it became necessary for the ward-personnel to tube-feed him, and there were many indications that he was hovering on the brink of death itself. During the therapeutic sessions I came then, progressively, to desist from all forms of therapist 'activity'; I had tried everything I could think of, and nothing had worked, and I concluded that he could emerge from this border-of-death state only through the expression, basically, of the life which one must rely upon as existing somewhere behind his so-inanimate demeanour. His emaciated form, lying face down on the bed, looked more like a rather large wrinkle in the bedcover than the outline of a living human body.

I found myself saying less and less as these sessions went on, until I reached the point where I was simply bringing in my chair and placing it in a stereotyped location several feet from his bed, saying, 'Hello, Mr —', as I sat down; sitting silently and comparatively unmoving (but comfortably so) throughout the session; and saying, 'Goodbye' or 'I'll see you tomorrow' as I got up and took my chair out at the end of the session—with, still, no discernible response, either verbal or non-verbal, from him.

Then came a session in which I simply brought in my chair and sat down, as usual, but without saying anything, and at the end of the session, as I got up and was starting out with my chair, again without any words to him, he suddenly raised up on an elbow, looked at me and asked,

in a loud, clear, astonished tone, 'Aren't you even going to say goodbye?' It was this session which, in retrospect, marked the turning-point, for this man, from moving-towards-lifelessness to movement-into-living. He went on, subsequently in our work, to evidence far more of a rich aliveness than any one, whether among the hospital personnel or among the members of his parental family, had thought possible to exist in him, and I found abundant evidence to indicate that my contribution to this recovery-process sprang from, as much as anything else, my having become able to tolerate, not only during these months I have been describing, but on many occasions in the subsequent years of the therapy,

the transference-role of, in essence, an inanimate object—the embodiment of the patient's subjectively unalive, inanimate personality-components, now safely externalized and susceptible to resolution in the transference-analysis. This is not the only instance in my experience which has pointed up, for me, the lesson that the neutral response is no mere luxury which the therapist can allow himself, no mere form of self-protection behind which he is enabled to hide from frightening feeling-participation with the patient, but rather is an immensely hard-won, and hard-maintained, state of feeling on his part which, in extreme instances, is of literally life-saving value to the patient.

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FRIGIDITY AND OBJECT RELATIONSHIP¹

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In past psycho-analytic explorations of the problem of frigidity, stress was put mostly on oedipal factors and the so-called castration complex. In looking back on my own contributions, I am aware that I, too, was mostly concerned with these points. To be sure, at that time, we lacked important tools and concepts to allow us to see frigidity in the broader aspects as an expression of a disturbance in object relationship. This became possible owing to our knowledge of the early development of the ego and the early stages of object or pre-object relationships. Our deeper insight into the pre-oedipal constellation proved of particular significance here.

Here I purpose to deal especially with what might be called objectal and ego aspects of frigidity. Moreover, as we shall see, this point of view will force us to see frigidity in a broader clinical perspective.

Former studies and observations of the oedipal or, speaking more generally, of the incestuous fixation, encompassed clinically patients who could be considered as hysterical. On the other hand, in cases with prevailing castration complex and penis envy, the clinical picture was related rather to the obsessive-compulsive structure.

From the point of view of object-relationships, we might say that in the former group the object remains incestuous; in the latter the total object, though also incestuous, was largely replaced by a partial object, namely, the phallus. In both groups of patients orgasmic experience had been prevented by specific libidinal and object relations which lead to clitoral hypercathexis and vaginal anaesthesia.

We find that disturbances in early stages of ego development may interfere in many ways with orgasmic experience. In the following example, transference in a curious way intrudes upon the sexual enjoyment of the patient and disrupts her sexual experience. A. had been

brought up by a psychotic mother and, without being clinically psychotic, presents some symptoms of ego fragmentation. In the morning, after sexual experience with her husband, she sees, upon awakening, my shoes leaving her. This to her means that in reality she was making love with me. Her childhood reminiscences indicate that she used to expect part of her body to fall off, to stay behind while she would inevitably follow her mother with whom she had a most unusual symbiotic relationship. Since she felt that she was but an appendage to her mother, she could not really envision herself remaining in the same room where she had had a love session with her mother, after the latter left the room.

We find that the persistence of the symbiotic relationship with one or both parents presents the most serious obstacle in the establishment of a true object relationship with a man. The interference with orgasmic experience is the result of many primary reactions and secondary defences.

The element of hostility inherent in every symbiotic situation adds momentum to the fear of the love object. When, in the course of early development, the ambivalent symbiotic attitude towards parents remains unresolved, it becomes quite naturally transferred to the new love object.

Among many factors which remain responsible for this development, we should mention, in addition to a neurotic, frustrated and possessive parent, the loss of a parent at an early age. The re-enactment of the old attitude of the ego leads to a specific constellation laden with anxiety and compounded with anaclitic clinging, hostility, and fear of loss. It is evident that this attitude is not conducive to the abandonment which the female ego requires for a full sexual enjoyment or what one might call the erotic regression in the service of the ego. Our observations permit us to penetrate deeper into the complexity of this situation.

¹ Read at the panel on Frigidity in Women, held at the Midwinter Meeting of the American Psychoanalytic Association in December 1960.

The symbiotic wish calls for complete and permanent fusion with the lover, yet the conditions of the sexual act preclude such fulfilment. Rather than permit 'the abandonment' by the lover, the ego withdraws its cathexis from the sexual act so that it can watch and observe, wait for the inevitable 'loss' of the love object; this loss seems but a repetition of the old childhood drama. In the transference situation these patients were particularly sensitive to the imaginary threat of abandonment by the analyst. Characteristically, time and again they tried to terminate the session by themselves, ahead of time, so as to avoid being sent away by the analyst.

The characteristic masochistic element of the clinical picture was stressed by masochistic acting out towards the husband, a well-known mechanism of masochistic provocation, meant to protect the ego from narcissistic injury, by creating a situation in which abandonment would be brought about by the woman herself, the very same woman who is most apprehensive about it. Characteristically, these women find it most difficult to bear loneliness, yet their extensive use of the mechanism of isolation condemns them to loneliness even in the presence of the love partner.

The ego resorts to isolation as a defence against the wish for complete and permanent fusion, the fulfilment of which is experienced as a threat for two main reasons: firstly, there looms the dread of complete absorption; second, the fear of the release of primitive hostility. We might say that both wishes are in reality in a reciprocal mirror relationship and thus reinforce each other. They seem to be nothing else than the elements of Lewin's oral triad. This statement calls for explanation: the fear of the desired absorption releases hostility: instead of merging with the parent (or a substitute), that is, instead of being devoured by him, the ego wishes to turn the tables and to devour. Moreover, the fear of abandonment which literally and inevitably follows the sexual act and deprives the woman of the male partner with whom she has merged, provokes the wish for either total or at least partial absorption.² 'I am a monster', said one of my patients. 'How can I have a love relationship with a man if all I want is to tear him apart?' The release of hostility directed towards her husband and his phallus had a complex structure, and some of its main features

can serve as an illustration of similar cases. It had its prime origins in the early pre-oedipal, predominantly oral and anal attachment to the mother, whom the little girl lost in her fifth year. This loss contributed greatly to accentuating the intensity of her oedipal attachment which was encouraged by her young bereaved father. He assured her that she was his only love; nevertheless, after a relatively short time he fell in love and married a young girl. Thus conditions were given for the pre-oedipal attachment to mother's breast and for the libidinal cathexis of her body being transferred to the father and his phallus. This early fixation contributed substantially to the quality of her oedipal wishes, thus her new libidinal goal became the merging with and anaclitic clinging to the father, incorporation and permanent retention of his phallus.

The establishment by the ego of the masochistic bond served as an important tool destined to assure the attainment of these aims (cf. Bychowski, 1959). Thus, helplessness, weakness, and relying on parental substitutes became essential attributes of the patient's personality, permeating her marriage and the transference.

It should become apparent that hostility in this patient released during the inevitably unsuccessful sexual act was the result of deprivation and frustration on ever so many levels. It was so intense that the ego had to protect itself and the loved partner by further isolation of the sexual experience and of the cathexis of the genital area.

Incidentally, such release of hostility culminating in true though often suppressed feeling of rage could follow in the wake of other frustrations as well: for instance, to mention only two essential situations, the relationship to the children and the transference.

Of particular interest here are two somatic manifestations of such hostility, either post-coital or provoked by other situations. The patient would wake up with her musculature taut and rigid, her jaws feeling tense, grinding her teeth; in her mouth, she would feel a few cankerous sores.

The persistence of archaic oral-sadistic desires interferes with the wish to give of herself in any relationship and especially with the entire scope of the love situation.

What these patients fear is giving too much and receiving too little. The masochistic attitude feeds on the image of the ungiving male. The

² A literary, somewhat frivolous, allusion to this *Drôlatiques*.

mechanism can be found in one of Balzac's *Contes*

fantasy of permanent exchange based on the masochistic bond interferes with the free flooding exchange which is obviously a factor of vital significance for a truly satisfactory love situation. Moreover, and this point cannot be emphasized strongly enough, there is the need to protect oneself from the impact of hostility, both one's own as well as that reprojected on to the love partner. Since the latter ought to be punished for past and anticipated abandonment, the woman in her turn must fear his wrath. All these fantasies culminate in the threat of annihilation. Thus, the ego lives on the brink of destruction which, paradoxically enough, may be inflicted by the love partner. In some cases the latter in his original parental form was really and truly endowed with hostile aggressivity. In such cases, the relationship remains a true love-hate relationship which then becomes transferred to the love partner of later years. In the patient mentioned above, such a situation existed, as a result of the true personality of her father. Here, then, the relationship with the father which had lent his features to the hostile and nagging super-ego was described by the sophisticated patient as a kind of sado-masochistic *folie à deux*: As she put it succinctly: 'I never loved anybody with such passionate hate.'

It should become clear from the material presented so far that the ego of these patients holds on tenaciously to oedipal as well as pre-oedipal love objects. Moreover, it is filled, as it were, with introjects, relics of original objects, beloved persons who had been lost as a result either of true bereavement and/or destructive hostility of the young child. This situation obviously interferes in many ways with full sexual abandonment. In the first place, the ego fears that by abandoning itself to the lover, it will forego its claims to the original love object. In some patients this attitude assumes a concrete form of waiting for the lost parent who may return like a ghost to claim his beloved. This moment of blissful reunion may be missed by her, however, should she abandon herself to the full embrace of another lover. Consequently, an attitude develops according to which the lover is not regarded as a permanent love object, since the main cathexis is reserved for the original love object or rather the introject. This lack of permanence adds up to the impact of old loss or losses which had taught the ego not to believe in the permanence of any love relationship.

A third factor interfering with the constancy of the love object is, of course, the full impact of

highly ambivalent cathexis loaded with strong pregenital contributions. While waiting for the return of the lost beloved and resisting full self-abandonment to the actual lover, the ego has to maintain the attitude of watchful vigilance. The patient has to keep herself prepared for the return of the original love object, an event which should not catch her unaware. She must also watch the actual lover who, according to her fearful anticipation, is always ready to abandon her. She has to make sure, in the words of one patient, 'that he gives me enough', and above all, she must observe herself so as not to allow herself the complete surrender.

This patient who lost her father at the age of 2 used to relive this loss on various occasions of parting or leave-taking. Of these the most significant was the sexual act. Speaking of her husband, she said that she was trying to dissolve him as an object, that is, decathect him and thus prevent her own anger at his abandoning her. She felt that her husband came and went just like her father. In situations where she should have been vitally involved, motherhood, marriage, learning, and work, her ego was never entirely present. This partial withdrawal was particularly manifest in the sexual situation. She spoke of looking away and of the flight of her ego during the sexual act. Remaining on the infantile level of incompetence seemed to her the most expedient way of cementing her bond to the paternal ghost. She said: 'I want to get something from my great father but not to become somebody by myself.' Thus she produced learning difficulties, unclear thinking, and above all serious disturbances in her ego feeling. She felt that such ego powers as thinking, reasoning, learning, and coming to terms with reality were not hers but were borrowed from her father, just as she had borrowed some of his diseased organs during the fateful days of his illness. Moreover, since these faculties were hers on loan, they could be taken away at any moment. In refusing to commit herself wholeheartedly to her surroundings and accessible reality, the patient experienced feelings of depersonalization. In vital situations, she maintained the disturbing split between the observing and acting ego. Identifying with the parental images, she watched herself, thus reaffirming the bond between her parents and her ego: 'They are watching me; I am watching myself.' Another important source of this attitude was the reversal of scopophilia: now her parents did the watching instead of being watched by her. In this way the patient

could remain unrelated to people, continuing to feel like an abandoned child in search of parents: 'Since my father is not here, I am absent as well, looking for him instead of reality, like children who hide their toys and then look for them: I am never completely with another person, my father is always present.'

To these factors, which obviously must be regarded as essentially of pre-oedipal origin, there must be added contributions from later stages of development. Here, watching repeats the anticipation or observation of primal scenes so that the patient re-enacts the old drama in a version in which she plays the role of observer as well as object of observation. With all this, it may be said that these patients have an attitude of partial depersonalization at least in the area of sexuality. Their world is a pseudo-world just as their love is a pseudo-love. However, we should not be surprised that, on closer observation, this alienation pervades other areas as well. The world of objects is never fully cathected, since these patients live partly in the world of archaic objects and introjects.

Here we come to another consequence of the persistence of old objects within the ego of these patients. One can say that their self is overcathected in keeping with the attitude of increased self-observation. When applied to the bodily self, this gives rise to hypochondriasis. In an onrush of symptoms, as one patient put it, various organs became, as it were, independent from each other, as though they would rebel against the 'me' like the organs of the body against the brain in the old Roman fable. The patient has no more power over them; they represent her dead father, her ties with him, her introjection of him.

We understand that our patients find it difficult fully to cathect and to admit new objects. In dreams and fantasies they experience themselves as filled with archaic objects which do not leave enough space for new ones. These introjects may fill not only their mind but, in a more literal way, various bodily cavities and orifices, preferably the genitals. It then becomes one of the tasks of psycho-analysis to help the patient to liberate the self from these relics. To put it quite bluntly and poignantly: the patient cannot respond favourably and receptively to the phallus of her lover as long as her vagina is filled with the paternal penis and her oral cavity with the maternal breast. In derivation, the ego finds it difficult to absorb or to cathect new contents; the ego closes itself to new knowledge,

and an attempt at concentration causes anxiety. There is apprehension about new contents taking the place of old introjects.

This unique combination of being filled with the object of the oldest wishes and yet being possessed of an insatiable desire for impossible fulfilment is perhaps the most salient characteristic of these patients. In the search for gratification, the ego resorts to most varied reaction patterns. We will only mention in passing the well-known pattern of compulsive promiscuity where moral masochism often plays the most important part, in addition to the sadistic impulse of emasculation directed originally towards the parental imago and subsequently at its actual and real substitutes.

In individuals related to the schizophrenic group, the split of the ego and of the sexual object provides for a typical pattern. The dissatisfaction verging on despair of ever attaining sexual gratification, that is, according to the unconscious wish of women of this group, to become reunited to the original love-object, leads to the development of peculiar autoplasmic mechanisms. One patient fantasied that keeping her bladder full would provide her with a full breast; yet out of the clitoris, under the impact of masturbation, there would grow the penis as a substitute for the paternal phallus. In frequent compulsive urination which, as a transient symptom, she developed during her psychoanalysis, she hoped first to produce and then to expel this imaginary phallus. In the acting-out of this symptom, during the sessions, she also hoped for the fulfilment of her infantile wish to be attended in the bathroom by her father. The infantile wish for a child from the father as a substitute for his phallus may in the autoplasmic fantasy focus on bodily contents, thus regressing to the anal and urethral stage; possibly this constellation may interfere with the woman becoming pregnant. Most certainly, it interferes with a mature attitude towards the child as a separate individual.

It should become apparent that such autoplasmic fantasies serve as foundation for the myth of autarky, to be sure, one of the basic unconscious wishes of these patients.

In another aspect of the autarkic fantasy, the patient may hypercathect the intellect, endowing it with the meaning of phallic aggression. Consequently, intellectuality may become the object of the very same inhibition which served to prevent independence from the original object. In this case the attempt at autarky may result in

the breakdown of some of the basic functions of the ego: thinking and memory suffer. Clinically, patients to whom I referred in my previous remarks can be described as narcissistic personalities with a depressive core. The latter accounts for the role of reactions of early grief in their development. I believe we can speak here of a chronic latent depression (Bychowski, 1960).

Finally, I would like to delve into aspects of frigidity presented by individuals belonging or closely related to the schizophrenic group. In one type the sexual partner is thought of as a true substitute for the parents in an early symbiotic relationship. In extreme cases the weakness of the ego is such that physical closeness to a man is thought of as a source of strength and a remedy against unbearable loneliness. Here frigidity may be complete, since pregenital fixation and possibly incest taboo prevent the orgasmic experience. The search for love and orgasm, impossible of attainment, may lead to compulsive change of sexual partners. In addition, a strong sadistic component and castration anxiety with reactive penis-envy may induce the woman to defeat a succession of sexual partners by her lack of response.

The prevalence of an oral fixation and typical schizoid defences which the infantile ego had evolved as a protection against the archaic symbiotic wish, may result in a clinical picture compounded of anorexia nervosa, oral phobias and compulsions, and sexuality characterized by frigidity and symbiotic affairs of homo- and heterosexual nature.

In patients with an advanced split of the ego and of the love-hate objects, the clinical picture may be that of a complete dichotomy of sexuality. In one patient the husband took the place of the negatively cathected parental introjects, and the home itself, despite the children, became a prison from which the patient felt compelled to escape at any price. Nevertheless, she turned towards her husband as a protective parent and tried to return from her escapades to her home as long as possible. In the meantime her libido turned towards haphazard casual partners with whom she could experience orgasm and who for a while became objects of some imaginary passionate love. Lack of emotional response on their part, in view of the deficient reality-testing of the patient, made for some time very little dent in her conviction that this was the passion for which she had been waiting all her life.

The transference situation as well may provide

the opportunity for such a delusional development. My patient thought of herself as possessed by her former therapist who had interrupted therapy after a short while. In her psychotic actions, the patient acted out all the worst trends of bad parents, and in her self-devaluation repeated the depreciation of her mother by her father. The latter accused the mother, who had left him for another man, of being a prostitute, good only for sex, not worthy of love.

Thus, in identification, the patient looked upon herself as a prostitute who had to throw herself on strangers. She spoke of her husband with hatred and yet, despite all her escapades and even after her divorce, continued to live with him for years. It was clear from her dreams that she was denying and isolating all her existing positive feelings towards her husband who became identified with the negative aspects of her parents. While projecting on him her hostility, she accused him of indifference and, against all the evidence to the contrary, of the wish to walk out on her; in reality, it was she who abandoned him on many occasions. With some progress in therapy, she became aware that she might even love her husband, but expressed strong reservations about the propriety of her father's feelings for her as a young girl and about her own husband's holding her daughter's hand.

Finally, as a last form, I would mention briefly what might be called relative frigidity. We all know that a woman may be frigid with one sexual partner and fully responsive with another. Since this very often hinges on some sexual deficiency in the former, such a situation would not be of any particular interest from our point of view. What I have in mind, however, is a situation where, for unconscious motivation, the woman selects a husband to whom she cannot and does not respond.

Such a husband may be described not as a love (or sexual) object, but rather as a defensive protection against sexual love. His qualifications for such a role lie in the most striking contrast he presents to the original incestuous love-object or objects. Such a definite and strong dichotomy seems to demand as a background a structure of latent psychosis, with the ego filled with bizarre archaic introjects, derived from pathological incestuous love-objects of early childhood. In one such patient the original love objects consisted of highly pathological family members: both parents and an older brother.

In her marriage this woman remained frigid and completely unfulfilled, yet strictly faithful

to her husband. Once this vow of marital loyalty broke down after long years of unhappiness, she experienced ecstatic sexual fulfilment with a man whose psychic structure was that of a latent schizophrenic and who, in many ways, reminded her of her original familial love-objects.

Conclusion

After this brief outline of regressive elements in some clinical forms of frigidity we become even more aware than ever of the importance of

early object and pre-object relations as a basis for future development and pathology. In this development any weakness may interfere with future object relations and the ability for full sexual experience. The attraction of such foci of lesser resistance as a vector of regression should not be underestimated.

The study of frigidity seems to confirm Freud's statement that, to speak teleologically, 'Nature has paid less careful attention to the demands of the female function than to those of masculinity' (Freud, 1933, ch. 5).

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ALICE AND THE RED KING

The Psycho-Analytic View of Existence

By

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An investigation of the phenomenon of existence has engaged philosophers and theologians for many centuries. In recent years interest in the subject has been awakened in students of human behaviour by the writings of the so-called existentialists. This paper will discuss the concept of existence from the psycho-analytic point of view. It will be treated as a phenomenon of ego development and as an on-going activity of ego function.²

The term 'existence' as used in this paper will refer to the awareness or appreciation of one's existence. A piece of furniture exists, but has no knowledge of its existence, nor does it have any fears of non-existence. The subjective quality of human existence is contingent upon a perceptual system and particular elements of ego mastery. The concept of human existence, a subject which has been discussed by philosophers through the ages, is explainable along well-known psychodynamic lines.

My interest in the concept of existence began when a patient reported an unusual dream:

'There is a giant lying on the grass. There is a big round circle above him indicating that he is dreaming (like in the comic strips). I'm in that dream just doing ordinary things. I get the idea that I exist only in his dream. It is important for him to stay asleep, because if he wakes up, I will disappear. This is a tremendous fear.'

The dream reveals something important about the patient, even without further background on the case. We suspect the patient has a very tenuous hold on reality, and that a plausible cause for this was a serious problem with the patient's father. Furthermore, we would suspect the anxiety expressed by the patient to be related to primitive urges for self-preservation and union with a parent.

The patient, Xenia T., was a 36-year-old single woman who entered analysis because of severe anxiety over recurring thoughts of becoming psychotic like her brother, who was a patient in a mental hospital. Her father, a physician, urged her to get assistance because of her extreme obesity, which could not be controlled because of her compulsive eating. The patient was not seriously concerned about her weight, which probably exceeded 250 lb., and she had no desire to change her eating habits.

Her speech mannerisms presented particularly outstanding characteristics. She was very loquacious, and spoke in a loud voice as if addressing a huge audience. She gave the impression that she must continually make her presence felt, yet at the same time she always considered herself very insignificant. She was always surprised when others recognized her or listened to what she had to say.

The patient considered herself a thoroughly dependent person, as indeed she was, but she acted in a bossy, officious, managing manner whenever she had the opportunity. She was fearful of men and marriage. She used her obesity as a foil for warding off romantic involvements. As a child she never wanted to be a girl. She played football with boys and avoided all feminine activities. This pattern persisted, one example being her exaggerated interest in spectator sports. Although her homosexual inclinations were well defined, she showed no tendency towards overt homosexual behaviour. Her disturbance in object relations probably derived from the fact that she saw very little of her physician-father. Her mother, a bacteriologist, was more aggressive and authoritative than her father, and nurtured and punished the children. Although the patient knew many people, she never allowed herself to be close to anyone, male or female; on the other hand she was devoted to her two dogs. Although a peculiar person in many ways, she functioned to her own satisfaction until the age of 25, when her mother died. Shortly thereafter her maternal grandparents died and her brother became psychotic; she watched

term function as 'those observed consequences which make for adaptation or adjustment of a given system'.

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² I am employing Merton's (1957) definition of the

him develop delusions of being Jesus Christ. Her fears of insanity then took hold of her, and her character traits and compulsive actions became intensified.

From her early childhood she exhibited strong scopophilic and exhibitionistic drives with their accompanying reverse polarities, namely, the inability to notice things about her and the fear of being noticed. She also struggled with the opposing motivations of omnipotence and helplessness. In an attempt to cope with her conflicts she remained regressed to an early level of infantile thought processes. From an early age she centred her thinking around the idea that her very existence was contingent upon the maintenance of a masculine image. She accomplished this by incorporating some aspects of her father which led her to eat like a man and talk like a man. An early memory of her father eating a poached egg on toast in four bites impressed her considerably.

Although the patient professed a great deal of hostility to and fear of her father, it was revealed in working through her oedipal situation in the transference that her greatest libidinal gratification came from being at home while her father was asleep. Her loud talk and eating habits were related to the dinner-table situation when her father was at home. The wish-fulfilment function of the recurrent dream can be understood from learning of the patient's enjoyment of her father's presence at home and the absence of criticism from him when he was asleep, along with his tendency to leave her and ignore her when he was awake. The groundwork for her underlying fears of abandonment and oral preoccupations had been laid earlier, when her mother left her for a period of nine months during a long illness beginning when the patient was 1½ years old.

Let us now return to the dream. When Xenia first reported it she attached little significance to it. As the analysis progressed there was occasion to refer to it many times both as an interpretation and as an association by the patient. Xenia gave some structure to the dream by stating that she sometimes did not feel real and might vanish as a dream vanishes when a person awakens.

Whether by accident or by motivation from some unconscious forces set in motion by this patient's dream, I picked up Lewis Carroll's *Through the Looking Glass*. My attention was arrested by the following passage:

... she checked herself in some alarm, at hearing something that sounded to her like the puffing of a large steam-engine in the wood near them, though she feared it was more likely to be a wild beast. 'Are there any lions or tigers about here?' she asked timidly.

'It's only the Red King snoring,' said Tweedledee.

'Come and look at him!' the brothers cried, and they took one of Alice's hands and led her up to where the King was sleeping.

'Isn't he a lovely sight?' said Tweedledum. Alice couldn't say honestly that he was. He had a tall red night-cap on with a tassel, and he was lying crumpled up into a sort of untidy heap and snoring loud—'fit to snore his head off!' as Tweedledum remarked.

'I'm afraid he'll catch cold with lying on the damp grass,' said Alice, who was a very thoughtful little girl. 'He's dreaming now,' said Tweedledee: 'and what do you think he's dreaming about?' Alice said. 'Nobody can guess that.' 'Why, about you!' Tweedledee exclaimed, clapping his hands triumphantly. 'And if he left off dreaming about you, where do you suppose you'd be?' 'Where I am now, of course,' said Alice. 'Not you!' Tweedledee retorted contemptuously. 'You'd be nowhere. Why, you're only a sort of thing in his dream!'

'If that there King was to wake,' added Tweedledum, 'you'd go out—bang!—just like a candle!' 'I shouldn't!' Alice exclaimed indignantly. 'Besides, if I'm only a sort of thing in his dream, what are you, I should like to know?'

'Ditto,' said Tweedledum.

'Ditto, ditto!' cried Tweedledee.

He shouted this so loud that Alice couldn't help saying 'Hush! You'll be waking him, I'm afraid, if you make so much noise.' 'Well, it's no use your talking about waking him,' said Tweedledum, 'when you're only one of the things in his dream. You know very well you're not real.'

'I am real!' said Alice, and began to cry.

'You won't make yourself a bit realer by crying,' said Tweedledee, 'there's nothing to cry about.'

'If I wasn't real,' Alice said—half laughing through her tears, it all seemed so ridiculous—'I shouldn't be able to cry.'

'I hope you don't suppose those are real tears?' Tweedledum interrupted in a tone of great contempt.

'I know they're talking nonsense,' thought Alice to herself: 'and it's foolish to cry about it.' So she brushed away her tears and went on, as cheerfully as she could. . . .

I asked Xenia if she had read *Alice in Wonderland* or *Through the Looking Glass*. For a long time she steadfastly denied ever having read or heard anything of these books. Later she admitted she might have glanced at the 'Alice' books, but said that she had never liked them. Rather, she indicated that she associated the giant of her dream with Jack and the Beanstalk and Robin Hood and not with Alice. If she had heard the story of the Red King she probably repressed it, because of her need to deny her libidinal interest in her father. However, it is likely that Xenia's dream arose from purely intrinsic sources. I feel that we are obliged to

conjecture that Lewis Carroll's fertile imagination and the patient's neurotic imagery must have originated from comparable sources.

It is surprising that the type of dream Xenia reported does not occur more frequently, since it is so closely bound to the primitive concept of existence. The basic 'need for attention' which is such a universal motivation in childhood is actually a search for reassurance that one's image appears in the mind of a person important in the life of the individual.

It is interesting that the dream-fantasy of both Xenia and Alice represents the projected thoughts of a little girl into the mind of a powerful father-person, and this could reveal much about Lewis Carroll's thought processes. Greenacre's (1955) study of the life of Carroll is helpful here.

Both Xenia and Lewis Carroll were strongly influenced by magical thinking. Carroll (actually Charles Dodgson) was a mathematician. This suggests that he used the precision of numbers to control his impulses. His other identity, that of the writer, permitted him to give vent to all his sadistic and erotic impulses, albeit in a non-sensical whimsical fashion. Dodgson was a shy individual with strong ties to his mother. He both admired and feared his father. He found it difficult to speak to him, and when he did he stuttered badly. My patient used loquacity as a defence, but at the same time she never looked a person in the eye when she spoke. Carroll displaced his imageries on to Alice Liddell, who served as an object of identification and gratification. His interest in little girls was a displacement and denial of his libidinal ties to his mother. Likewise, Xenia also showed sexual interest in little boys and older people, but fled from her contemporaries.

Carroll and my patient had poor relations with their fathers. No behaviour seemed to make any impression on their fathers, at least so both thought. As a defence against the fearsome qualities of his father, Carroll depicted his authoritative male figures as weak, emasculated men, e.g. they either blundered or fell off their horses, or, in the case of the Red King, were asleep. His women, on the other hand, were

strong and punitive. My patient, like Carroll, was never able to cope with masculine men. She had a few male friends who were obviously homosexual. With them she felt safe.

A characteristic of the Alice stories is the use of disappearance as a form of punishment. Greenacre considered the vanishing of the Cheshire Cat as a castration phenomenon.³ If this is plausible, Xenia's dream might also be looked upon from this point of view. In therapy however, interpretations at this level were not too successful. It turned out that the extent of the anxiety experienced by Xenia, and perhaps by Carroll as well, was of a more archaic nature; it embodied the concept of nothingness, of non-existence, of death. Carroll reduced some of his fears by converting them into grotesque nonsense fantasy. My patient, too, defended herself by incorporating the masculinity of her father, and by making her presence felt through her large size, her loud voice, and her overbearing manner.

Greenacre's study of the life of Lewis Carroll was helpful in understanding some of my patient's thinking processes. Her dream of appearing in the dream of a giant whose awakening would make her disappear was similar to the fantasy of the dream of the Red King in Carroll's story. Greenacre's statement that the Alice books 'reproduce the spirit of the preverbal era' was thoroughly applicable in the treatment of the patient.

Inasmuch as disappearance from the mind of a parent image leads to fear, we are obliged to assume that presence in the mind of the pertinent parent leads to gratification or satisfaction. It is this very point which I would like to emphasize here as constituting the phenomenon of existence. As such it represents a phase of ego growth, and is one which has its derivatives in an on-going ego function.

The concept of existence as dependent upon the image in the mind of a parent figure is an ancient one. In the Hindu religion, particularly the Vedanta, the existence of man is predicated upon the dream of the deity. The dream of the supreme creative power (Īśvara) controls the entire cosmos. Actually it is not a sleeping dream, but is described as an act of cosmic

³ The castration phenomenon bears some relation to the fear of non-existence or death. Some analysts believe that the fear of death is derived from the more basic fear of castration. It is more reasonable to feel that castration anxiety is partial death, i.e. mutilation, and is of a less archaic nature than death itself. In this respect we can utilize the concepts expressed in this paper to understand some other symptoms of human behaviour, particularly

sexual exhibitionism. When the man exposes his penis to a strange woman, his greatest libidinal charge comes from his organ having been seen. This assures him that it is still there. This may also explain the absence of female genital exhibitionism and the prominence of female breast exhibitionism, because it confirms the fact that something is there.

ideation. It is believed that man's existence is created by the thought processes of Ísvara, and man's existence as such ends when the deity goes to sleep. The whole universe is created and destroyed in alternate cycles, depending upon the successive thinking and non-thinking of the Supreme Being.

The concept of the awareness on the part of the deity controlling the existence of man is the reverse of that of existence being dependent upon the sleeping figures of the giant and the Red King. But the relationship of the psychic process of the parent figure and the phenomenon of existence is unmistakable.

The Greek philosophers, Plato and Aristotle, laid the groundwork for the later religious philosophers in Judaism and Christianity. The Judaeo-Hellenist Philo (see Wolfson, 1948) stated that God has a direct share in the rational and irrational processes of the soul:

'But neither has the mind the power to work, that is, to put forth its energies by way of sense perception, unless God send the object of sense as rain upon it.'

The concept that the existence of man is dependent upon God's awareness was propounded by St Thomas Aquinas in his *Summa Theologica*. He quoted the New Testament: 'Upholding all things by the word of His power' (Heb. i. 3). He stated that both reason and faith require us to say that creatures are kept in being by God, and quoted Augustine: 'As the air becomes light by the presence of the sun, so is man illumined by the presence of God, and in his absence returns at once to darkness.'

Maritain (1948) expounds the Catholic view of existence by quoting St Thomas, and adds a few observations which have psychological and/or philosophical implications. He speaks of existence as a subjective phenomenon of perception with the added ingredient of 'essences' or 'natures' which are reflections of divine linkages.

The philosopher Bishop Berkeley (Wild, 1936) had a great deal to say about existence. He reasoned that objects exist only because we perceive them. This led him to subscribe to the principle of *esse est percipi*, i.e. to exist is to be perceived by some mind. He next went on to say that individual human existents exist in the mind of human persons as well as in the mind of a Supreme Being. From this he believed that he had adduced a proof of the existence of God.

In the commentary by Gardner (1960) in *The*

Annotated Alice there is a suggestion that Carroll consciously used the concept of Alice and the Red King as a reflection of the Berkeleyan theme. He also pointed out that the dream of the Red King has been the source of much discussion among philosophers, including a recent radio panel discussion in which Bertrand Russell made mention of it.

It is beyond the scope of this paper to review all the ideas expressed by philosophers through the centuries regarding the phenomenon of existence. It does, however, seem necessary to discuss the subject briefly from the point of view of the existentialists, particularly because they claim to be in disagreement with Freud.

They describe two elements in the formation of an existence, namely, the 'natural' and the 'ontological'. The 'natural' factors are presumably the anatomical and physiological realities of the organism. The 'ontological' are more difficult to understand. It is my impression that because the existentialists have not been able to explain existence along 'natural' lines, they have brought in older metaphysical ideas.

Ontology is defined as the science of being or reality. It is considered to be that branch of knowledge which investigates the nature, essential properties, and relations of being as such. In this connexion, May *et al.* (1958) offer the statement that man must be understood in terms of those characteristics which make him human and without which he could not exist.

Kierkegaard (1844), the father of existentialism, was a religious man who explained the concept of existence on purely theological lines. Maritain also, it was pointed out, adheres to the notion that the desire for being and the anguish over not-being is resolved by faith in God. The 'atheistic' existentialists, namely Heidegger (1927), Sartre (see Greene, 1960) and others, have a more difficult time explaining existence. In fact, they do not explain it at all. They say, 'We exist because we exist'.

Heidegger refers to the union of man with his environment as the phenomenon of 'being-in-the-world'. Sartre refers to two aspects of existence, 'being-in-itself' and 'being-for-itself'. Being-in-itself possesses reality and is what it appears to be. Being-for-itself or 'nothingness' is presumably synonymous with human consciousness. This to me is a totally incomprehensible concept. It may be Sartre's particular way of dividing the natural from the ontological. The difference lies in the concept that Sartre says that man conquers his feelings

of nothingness or non-existence by the use of the will, whereas the theologians turn to faith in a Supreme Being.⁴

It seems clear that the concept of 'being' versus 'non-being' represents nothing more than the operation of the survival or self-preservative instinct. Non-existence is the basic threat to survival, the threat of disintegration of the self. In infancy and in neurotic persons it is the threatened loss of the primitive ego integrity. The disturbances in the state of being or existence, whether they emanate from the outer world or from within the individual, still do not explain the positive fact or awareness of existence itself. What I am attempting to do in this presentation is to bring out in scientific terms the concept that can best be epitomized by the words 'I am'.

The existentialists on the one hand resort to mystic mental gymnastics and on the other take basic phenomena for granted. The 'I am because I am', says nothing. This is resorting to *a priori* reasoning, which has no place in our scientific world. It violates the basic principles of mathematical logic, which states that we cannot use one system of calculations to prove something within the same system. Stated differently, certain seemingly inconsistent statements made in a logical system cannot be discovered by the logic of that system (Salvadori, 1960).

It has been difficult for me to grasp any truly scientific aspect of the so-called ontological factors. We hear such phrases as 'beyond all time', an 'unmeasurable dimension'. When pinned down for more exact definition, an ardent existentialist (Van Dusen) stated that ontological is synonymous with 'religious'. This, of course, brings us back to such concepts as the 'soul', 'divine essences', etc., which have been amply postulated by Jung.

In close relation to the subject at hand, Jung (1921) differentiates the 'ego' from the 'self'. He considers the ego as being formed by the consciousness of environmental phenomena which make the child aware of his own body. 'Self', on the other hand, he equates with the 'soul', which is a cosmic or mystical element in the psyche derived from a collective unconscious, and manifests itself in the dream, in religious ecstasy, in rapture or erotic entrancement. He

could very well have applied his terms the other way round, making the consciousness of the body the self, and the ego the soul.

The Metapsychology of Existence

From the point of view of the ideas developed in the first part of this paper I will suggest a few points which may help us to understand the concept of existence as a phenomenon of human development. Certainly, Freud did not emphasize existence as such, but his writings (1920) indicate cognizance of it in many ways. On the other hand, in some writers there has been a hypertrophy of interest in existence to the extent that it is the *sine qua non* of all their philosophy and psychotherapy (Kalman, 1959; Weigert, 1960).

The anxiety experienced by Xenia can very well be described as 'existential anxiety', the term introduced by Heidegger. A better term is 'existence anxiety'. My patient was worried that if her image were not present in her father's mind, she would no longer exist. Since this manifestation seems so closely bound to the basic self-preservative instincts, it suggests that it is an archaic form of thinking that may be quite universal in the growth processes of human beings.

Before proceeding further, I would like to establish a clear-cut differentiation between fear and 'anxiety'. For example, May, who has done much to spread the teachings of existentialism, has often said that he developed his ideas when he was lying ill with tuberculosis. He stated that he could not explain the feelings that he and his fellow patients were experiencing in terms of Freud's concepts of anxiety, namely, the emergence of repressed libido or the threat of losing a loved object. Instead he found comfort in Kierkegaard's description of anxiety as the struggle of the living being against non-being.

May goes on to state that what he immediately experienced was the struggle with death or the prospect of being a lifelong invalid. Certainly, he experienced painful affects, but this was not anxiety, it was real and actual fear. By definition, anxiety is the experiencing of fear with no known or visible cause. He had plenty of cause for experiencing self-preservative threats without invoking such things as repressed libido. There was a threat of loss, the loss of his own life and

⁴ Varying degrees of adherence to mystical, magical, or metaphysical ideas have been expressed by numerous thinkers on this subject. Authors not referred to in the text are many. For more extensive reading on this

subject, the following names are offered: Nietzsche, Jaspers, Marcel, Merleau-Ponty, Jeanson, Dondeyne, Luijpen, Minkowski, Reinhardt.

the Eucharist leads the individual to a state of grace within the framework of the Church. This is a special form of existence which places one in the position of being favoured with God's mercy over and beyond his justice. It is a super-natural gift bestowed upon man for his salvation.

The favour of being in a state of grace is that which is to be attained in heaven. The ultimate reward is the beatific vision. This vision is the immediate sight of God in the glory of heaven, as enjoyed by the blessed dead. In other words, there is an anticipation of a new level of existence, the perpetual one, that of immortality. If one observes and is observed by the immortal parent, one attains immortality oneself.

A devout Catholic patient demonstrated the theme of this presentation during one of her analytic sessions. She was a rather disturbed young woman who had one acute schizophrenic break, but who was making a fairly good adjustment at the beginning of her analysis. She was happily married and engaged in professional activities, but was hampered by severe recurrent anxiety spells. These are her verbatim remarks:

'From the time I was in the sixth grade I became afraid of people. I felt inferior to everyone. I became studious and felt that I had to be perfect. I was a good girl in God's eyes. This held me together. I knew God loved me. He cared for everyone in a special way. Even if I were the only person in the world He would die for me. Because I was always in a state of grace He knew I existed. This kept me alive. If not for this I know I would have died. As long as I believed in God I knew that He would not turn away from me.'

At a later session this patient became very distressed about the hereafter. She said that she was afraid of Heaven because you cannot be married there, and she would miss her husband. Apparently the live human relationship with her husband had become more important than the mystical one with the Deity which at one time had been of supreme importance to her.

Melanie Klein (1958) believes that the destructive impulses are primary motivations of the infant, and that the loving mother acts merely to neutralize these forces, thereby imparting to the child the feeling of life. Separation from the mother merely accentuates the aggressive impulses, which are presumably derived from the

death instincts and are projected outwardly upon the mother. This gives rise to the phenomenon of persecutory anxiety. Stokes (1960) subscribes to this view along Kleinian lines, but adds some interesting observations. He states that the sense of loss of the mother brings with it a 'taste of death', since it is the first libidinal reaction to the pull of death. This involves the duality of life and death instincts, which has not been accepted by all analysts. It is this 'taste of death' that we can speak of as the fear of non-existence. The primitive fear of death need not be predicated upon a death instinct, which rather suggests a wish for death. The innate fear of harm is exhibited by all animals who fear the threats of known or unknown dangers. In the case of the infant the death threat does not emerge from the actual threats from the outside, but rather from the absence of the gratifying or neutralizing maternal image. As stated, Klein believes that the threat comes from the overwhelming aggressive impulses.

When there has been a minimum of threats or when the threats have been mastered by the organism, there are stored memories of gratification. It is the accumulation of stored memories of mastered experience that constitutes the ego (Solomon, 1954). This implies that the ego develops as an acquired psychic function. There is no need to postulate any other device or mechanism which seems to give the ego the properties of a special organ. Nor is there any need to theorize along mystical or magical lines when there are adequate explanations along purely biological principles. Freud spoke of the ego as a coherent organization of mental processes, also as the residue of abandoned objects. The second factor lends 'qualities' or 'character' to the ego. It is the collection of 'internalized objects', or what I would prefer to call the memory traces of the images of the important people in the life of the growing individual, which constructs the ego and in earliest life the first confirmations of the state of existence.

Let us examine a few more observable facts. Before the age of 9 months, the human infant acts as though objects which he cannot see do not exist. Later he learns to look for hidden objects and awaits the appearance and disappearance of the mother. Actually, the alternation of appearance and disappearance can become pleasurable as in the peek-a-boo game. The toddler closes his eyes or hides his face and believes that he is invisible. If he does not see you then he thinks

you cannot see him.⁶ From this the connexion develops that if the image of the parent is thoroughly implanted upon his mind, he senses that his image must be present in his mother's mind. When the child is certain that his image is present in his mother's mind he can share in her power.

The feeling of power that is derived from the mother at first comes from being actually in her presence. Dangers are dispelled when the child looks up from his crib and sees the reassuring countenance of the parent. It has been pointed out that this is the origin of prayer and the search for God high up in Heaven (Tarachow, 1960). Later, the child not only needs to see his mother, but needs the constant reassurance that his presence registers with her. Afterwards, the process of incorporation or internalization of the knowledge that one exists as an image in a loving parent's mind gives the child a sense of his own importance. This does not become complete in any individual. The residue of the need to be in someone else's mind is the need for attention and the constant search for being important to someone or to everyone. Exhibitionism and scopophilia are both derived from this source. Stated differently, existence is related to noticing and being noticed.

The concept of the wish to deny the existence of noxious or painful objects is seen in the negative hallucination. This is the basis for repression. Xenia did not want to look at conflictual areas in her life, therefore she did not see them, and they thus did not exist. She denied completely her sexual feelings, especially for her father; instead, she regressed to a level of merely existing in his mind. This was enough for her to survive. Consciously, she strove for a position of importance to her father but never expected to attain it. Hence she felt unimportant and strove to compensate for this in many ways.

Sibling rivalry is, of course, the classic example of how the child feels threatened when his image is replaced by the image of the brother or sister. The same is true of the oedipal triangle. We can adduce the fact that existence is an ego function from the quantitative degree of pre-occupation that individuals have with this modality. The individual suffering from a schizophrenic process is one whose ego is so poorly organized that he often displays an

inability to appreciate his existence. Such a person in therapy reports that he or she exists only in the presence of the therapist; when he leaves the therapist he feels he no longer exists.

A colleague who subjected himself to the use of LSD reported an interesting delusion that fits into the theme of this paper. He stated that while he was under the influence of the drug he did not want his wife and child to leave the room because he was afraid that if they did, *he* would disappear.

At this point I would like to differentiate existence from identity. We can subsume these two concepts under the headings 'to be' versus 'to be something'. Existence as an ego function comprises survival as an autonomous unit. The child has mastered some of his early survival needs, largely gastro-intestinal, and can function to some extent as an entity with an ability to utilize his external world only when specific needs arise. Let me quote verbatim the words of a confused 19-year-old girl who was making progress in therapy:

'It is important that my image must exist within you, so that you can be within me. I am aware of your strength—then I can have it within me. Now I feel that I can have life, a life of my own. I can face all the past that has happened to me and handle anything that may come up in the future.'

This clearly indicates the transition from existence to identity. It is the movement from 'I am' to 'This is who I am'. Existence implies survival; identity implies a design or style of existence. The 'who' is contingent first upon the clues in the communication system between mother and child, and later between the father and the child.

Many elements of ego functioning in the establishment of Xenia's existence and identity were revealed in the course of her therapy. She demonstrated many infantile introjections, projections, and reintrojections or 'projective identifications'. Her mother, for example, was looked upon as a good understanding mother upon whom Xenia depended. The cruel, hostile, unfriendly mother image was repressed and incorporated into her own image of herself. Thus, she considered herself to be evil and unworthy. This allowed her to maintain the mother image as a loving figure whom she needed

⁶ Variations of this theme occur in unstable people and some children who wish to combat fear by making themselves invisible. They close their eyes so that the burglars will not see them, or, even more fantastic, they try

to stop their thoughts and in this way to become invisible. Another derivative is the covering of the eyes at the masquerade ball in order to hide one's identity.

for the purpose of finding out what to do and how to act.

Xenia also projected a good image of herself into the mind of the father, as demonstrated by her dream. It also became evident that she reintrojected the male image of her father into herself. This led to her acquiring his masculinity as a spurious identity. She also displaced and projected her hostility to her mother onto her father, fortifying her own fears of his actual power over her. Defensively, her helplessness was also projected outwardly, allowing her to feel powerful and bossy over other people. This form of tyranny over the assumed helplessness of others gave her a reason for her existence and created a form of temporary ego mastery.

In the course of therapy with Xenia it was necessary to point up the various identification processes and their resulting conflicts as defensive manoeuvres in her efforts to survive. It was possible to relinquish these defences only after she had established a state of existence in the therapeutic situation. For a portion of time it was useful for the patient to sit up and face the analyst, so that the actual presence of the therapist and her awareness of herself as a communicant confirmed her own existence as a person.

The concept of existence as a person is still a far cry from the establishment of a true ego identity. An ego identity is essentially the integration of the self that has emerged in the various orbits of operation in which the individual lives, e.g. family, social situation, occupation, church, etc. Thus it is composed of such items as: sexual identity, family identity, racial identity, religious identity, occupational identity, etc. Out of this synthesis there is established a

sense of values, characteristic of the mature adult.

As a primitive developmental phenomenon the awareness of one's existence as an ego quality can be looked upon as being synonymous with reality testing. When there is disturbance in the contact-with-reality principle, it can be stated that there is an inadequate formation of the basic ego state of existence. 'To exist', 'to be autonomous', 'to be self-reliant', 'to have self-esteem', 'to be a free agent', are stages on the path to the development of an identity. None of these ego traits were fully established in Xenia. Her grasp of reality was tenuous, as Lewis Carroll's probably was. This has been well revealed in their strikingly similar distortions of reality and poorly developed ego traits of existence.

Conclusion

The metapsychology of existence as a mastery of the mutual perceptions that are recorded in the interrelationship of child and parent has been described. The development of the knowledge of one's existence, it was pointed out, is derived from the introjection of the primary object which had previously incorporated the subject. Stated differently, the child's sense of existence is contingent upon internalizing the mother who has internalized him. The archaic imagery associated with the threat of the loss of one's existence, namely the fear arising from the disappearance of one's image from another person's mind, can repeat itself with other pertinent persons in the life of the individual. The thesis is illuminated by the study of a patient's dream and by the writings of Lewis Carroll, particularly the scene of Alice and the Red King.

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FOR THIS WOMAN'S SAKE

Notes on the 'Mother' Superego with Reflections on Shakespeare's *Coriolanus* and Sophocles' *Ajax*.

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If Atlas carries the world, the Caryatids are seen supporting the roof of the front porch of the Erechtheum. Traditionally women have been the protectors of family harmony and unity, aligned on the side of social order and continuity. They keep the home fires burning. Isis in Egypt, Diana at Ephesus, the Virgin in the Christian world, and Athena for the Greeks are the great unifying forces of history. Militant against outsiders, Athena diverts the Achaeans from internecine hurts and grievances to the defence of the commonwealth (Lattimore, [1951], p. 64). She neutralizes uncompromising masculine aggression with patience and forbearance; and for the common good, she may incapacitate the offender as she did Ajax (Sophocles [ed. Grene and Lattimore, 1959]).

In this paper I shall deal with a character type vulnerable to a certain feminine influence which to casual observation might appear favourable and constructive. This influence is generally in the direction of taming and domesticating. The woman, responding in her traditional role, exerts pressure for the preservation of home, family, and country. To the susceptible male, however, this influence may precipitate a disintegrative process. In an earlier paper (Seidenberg, 1960) I have attempted to show certain preconscious factors operative in interpersonal relations which seem to precipitate mental illness in women. In those instances it was the solicitude of overbearing husbands which fixed doubts in their wives about their reality-testing capabilities. I will now present some clinical data and several literary allusions to show a destructive influence on a particular kind of male.

The character type to be examined is one very familiar to the analyst. Briefly stated, it is the male who operates in life as though the identify-

ing qualities of masculinity are belligerence, arrogance, vainglory, ruthlessness, as well as sexual insatiability. This image of what is maleness is prevalent amongst adolescents of both sexes. The term 'masculine protest defence' was first applied to the woman who would not give up her 'tomboyishness', and presented a masculine image in adult life, usually a caricature, as a reaction against fearful instinctual, and ego, demands. It can also appropriately be applied to the male who projects an image of maleness, held over from adolescent phantasies. We will, therefore, refer to this attitude and behaviour as 'masculine protest reaction' in the male. Although this defence can be shown to deal with complex pre-genital as well as genital conflicts, it is seen to be a reaction formation against an underlying feminine identification. Alexander (1930, 1938) described this type of behaviour in the male as overcompensation, i.e. overcoming the shame resulting from a failure to live up to one's ego-ideal of manliness. A vicious cycle is established. For the over-aggressive behaviour soon leads to fear of punishment from the superego. This aggressive behaviour then succumbs to passivity, inhibition of drives, and turning against oneself (Piers and Singer, 1953).

The motives for this hyperaggressivity, however, are overdetermined. Another source is the oedipal conflict itself. The boy, never able to show aggression towards his own father, displaces these feelings in full measure towards objects of the external world. Meek and docile in the family setting, his boldness knows no bounds outside the home. Herein is seen the classical splitting of objects. The paradigm of this splitting was the case of Little Hans. The white horse on the street and not the father was

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the fearful enemy towards which he could more safely express his fear and antipathy. At the same time, this behaviour unquestionably provides an outlet for homosexual as well as for aggressive cathexis. Fighting, quarrelling and competing with other men are central in their lives. Here, contacts are actively sought out and are well tolerated as long as the tender component is repressed and contact with orifices avoided.

We will begin with clinical data from the analyses of two men whose 'taming' led to severe neurotic disturbances, and will thereafter review similar character types drawn by Shakespeare in *Coriolanus* and by Sophocles in *Ajax*.

Case History I

A 36-year-old lawyer came to treatment because of depression, anxiety, and hypochondriacal symptoms. He had a fear of cancer of the bowels, of which his father had died five years earlier. He became depressed on anniversaries, especially those of the deaths of his parents. He had been an only child of immigrants, and had grown up in a slum neighbourhood. His father, a pedlar, made barely enough for subsistence. His mother bemoaned her fate in having become entangled with a ne'er-do-well, so that she rested all her hopes on her son. The family resources were wholly channelled to the son's education, which was now their only hope for social elevation. When the boy showed some deviant or truant behaviour which might cause him to veer off this course, his mother would demand that he be punished by his father, who usually complied with spankings, but without zeal. Father's only pleasure seemed to be a nightly trip to the corner drug store, where the pharmacist played pinochle with him during slack hours. He seemed fearful of both his wife and his son, but he often played with him, his term of endearment for him was an anal obscenity. The mother clearly indicated that 'maleness' had been wasted on her husband. Given the equipment, she would have put it to proper use.

The boy was closely guarded as to playmates and games. He was known as a 'sissie', but was reassured by his parents that it was because he was superior. At the age of 11 he became alarmed by recurrent nocturnal emissions, and privately consulted a doctor, who treated the condition with medication, which, the patient recalled, did little good. He subsequently went through college and law school; his success in law practice was early and substantial. But he was aggressive in his dealings, at times ruthless, and hovered on the outer margins of legality and ethical conduct. He had a flair for court work and preferred the toughest cases. Socially he was brusque, outspoken, and belligerent, often spoiling the welcome given both by his confrères and

other social contacts. He was a master of sarcasm, and his associates became his victims.

At the age of 28 he married. His wife, very attractive and well-educated, was a timid, fearful person. She was appalled by his boorishness, but attracted by the security he could offer. Thinking herself ostracized from social life as a result of her husband's behaviour, she set out on a vast 'point four' programme to rehabilitate him. She incessantly corrected his speech and manners. There were classes in social dancing, golf lessons, etc., to civilize him. She became very critical of his clientèle, since he frequently dealt with criminals and had a large income from them. She was appalled when they used to call him at home, and feared newspaper publicity. The spectre of disbarment was constantly with her. By cajoling and threats, she was able to 'reform' him in these ways. She held over him the threat of divorce with concomitant exposure, and expenses which would be destructive to him. She turned him, under threat, into a well-mannered individual, reforming also his professional life. He later rationalized this obedience and submission by telling himself that it was all for the good, that he was better off, well liked, less notorious, etc. However, as indicated above, he developed agonizing physical symptoms and obsessive thoughts which made him an anxiously subdued person. His preoccupation was mainly anal in character. He watched his stools, frequently handling them and examining them for blood, and would manipulate and rub his anus until it bled. He would then become terrified, running to his physician or proctologist for reassurance that he did not have cancer. There were concomitant menstruation and childbirth phantasies as the anal bleeding recurred. He too now had a receptive organ which bled regularly. There were problems of periodic impotence and self-castrative phantasies. He had the feeling that his razor might slip while shaving and cut off his penis. When staying in hotels, he would barricade the window lest he fall from it in a moment of forgetfulness.

Here we see strong preconscious forces in the pleas and threats of the wife and her need to fit him into a pattern desirable for her which resonated with unconscious conflicts and their attempted solutions. The resonance in this instance served to break down some of his defences, converting a character neurosis into a psychoneurosis. His feminine identification broke through under the impact of the wife's threats and passivity. A 'flight into sickness' ensued. Instead of being a belligerent, boastful person, he was now weak and preoccupied with his body. He became 'womanish' as defined by his unconscious.

As might be expected, the course of treatment was beset by several intrinsic technical problems. First of all, he came with the feeling that he was being sent by his wife for further modification, i.e. to meet her image of the ideal husband. To please the therapist,

he became even more passive, making a favourable social adjustment. Yet his symptoms increased in intensity and frequency. He 'retained' an internist and a proctologist on the side as added protection. It was difficult for him to overcome the feeling that the analyst was one more agent of his wife, out to civilize him.

The second but related problem was the intensity of the submissive dependency resulting from the return of repressed feminine identification. No longer belligerent and brusque, he 'settled down' on the couch, displaying that co-operativeness and docility which is death to genuine learning. Much of his time was spent in licking his wounds. The working through process was long and difficult, with several interruptions, some technical and others the result of acting out. After five years of treatment, however, the outcome has been favourable. His social adjustment is to his liking, and he does not lack self-respect. The hypochondriasis has diminished; the preoccupation with his anus and faeces has largely disappeared, although he still takes more than a cursory look at his faeces before flushing. He appears, too, no longer to need to be submissive to a father surrogate.

Case History II

A 28-year-old man came for help because of marital difficulties, anxiety, somatic complaints, and fear of disease. He had been married for three years, and had one child. The circumstances of the marriage were unfavourable and led to a great deal of disharmony. He had frequently dated his wife-to-be, but with no serious intentions; but she became pregnant and confronted him with this situation. He had ambitions to be a writer, and had no desire to settle down until he had experienced a full measure of freedom. The girl, however, threatened suicide, and great pressure was brought to bear by both sets of parents. He relented, gave up his personal plans for the future, and entered into the marriage. Instead of pursuing his creative career, he got a job in a factory where his father had been employed.

The couple fought incessantly; there was never enough money; each felt victimized by the other. They had difficulties in their sexual life, the patient suffering at times from premature ejaculation and impotence. One night, on returning from work, he found that his wife had left him, and returned to her parents with their infant. At first he looked on this as a good riddance, but as the days passed he became increasingly apprehensive. He had several acute attacks of anxiety and became fearful at being alone in the apartment. He was disturbed by the recurrent thought that he might be turning into a homosexual, and he suffered from headaches. An old back ailment recurred which gave him fears of having contracted poliomyelitis, and he saw himself turning into a nervous wreck, a state of being far different

from his former self. It was at this period that he sought treatment.

He related that he had a sister five years his junior. His parents were 'plain' hard-working people, and his father had worked through his lifetime at one plant, finally becoming a foreman. Unlike the patient, he was a plodding, uncomplaining person who seemed resigned to his fate. Nothing would arouse him save activities on the children's part which might disturb their mother; to these he reacted sharply, often with rage. The mother was a pious, sickly person who needed many gynecological operations which took most of the family resources; her chronic illnesses made her intolerant of noises and other household disturbances. The patient recalls that he became very hostile and at times envious of his sister, for she would generally escape blame for the things that could upset his mother, whereas he would generally bear the brunt of the punishment. Mother would easily become 'hysterical' on news of his misbehaviour. The women then appeared highly valued and protected. He grew up in a tough neighbourhood, and because of his small stature and belligerency became known as the 'one-two punch kid'. Also, because of his flair for books and learning, he was called 'doc'. At college he became a ferocious competitor in sports. He related that at one time his coach tried to slow him down: 'The object of the game,' he explained, 'is to win, not to kill off your opponents.' He could always be relied upon to outplay and outmanoeuvre his adversary. (Note Telamon's advice to Ajax; [Sophocles, trans. Grene and Lattimore, p. 241.])

He looked upon girls solely as sexual objects, and took great pride in the number of his conquests, but resolved to stave off any prolonged or permanent entanglement. On impregnating his wife-to-be, he felt no great moral responsibility, and would reluctantly have contributed financially towards an abortion, but did not want to go further. It was the combined pressure of the girl and his own parents which made him enter into the marriage. 'The disgrace would kill your mother if you didn't do the honourable thing,' his father admonished. So for his mother's sake and the girl's sake, he did the 'proper thing', which, he felt, was his own undoing.

The early part of the analysis was taken up with his current plight. His marital difficulties gave him new evidence of his awkwardness in dealing with women. He always seemed to have done everything at home which was upsetting to his mother; now the same thing was happening in his marriage. Now he wanted to continue in the marriage, hoping that his wife would return, so that he could prove that he could be an adequate husband. He thought it would be a relief to be a bachelor again, but now found going out with his former chums depressing. His difficulties with his wife also raised doubts in his mind about his maleness. Might he not be basically

a homosexual? This thought again gave him fears about associating with other men.

It became apparent to him that he was becoming preoccupied with bodily symptoms and obsessive hypochondriacal fears much like his mother's had been. He recalled in a casual way an operation of his own; mother wasn't the only one who was cut up. When he was 6 years of age, he was brought to hospital for a tonsillectomy. On awaking later in the day, he felt a painful sensation in his lower parts. Turning back the bed coverings, he found his penis bandaged. He recalls tearing away the bandages, and seeing his bloody genitals. It was later explained that since he was already under anaesthesia, the physician had decided to perform a circumcision which the parents had privately suggested. The patient gave this as an example of its being his fate to get it at both ends. But it also augmented his identification with his mother, where genitals were repeatedly mutilated.

This incident, although related during the analysis as a casual memory, proved to be a severe trauma. Whereas the tonsillectomy was thought to be punishment and correction for his oral aggressiveness (his noisiness on his part in upsetting mother), in his phantasies he felt that his secret sexual aggressiveness and masturbatory activity had been detected and attended to by 'excision'. The concurrent surgery in both these areas was undoubtedly felt by him as a reinforced castrative assault. His agnizing doubt was, had he been turned into a female? And, in the analysis it became apparent that there was an underlying predominant feminine identification which was successfully covered by his aggressive attitudes and behaviour. His fears of poliomyelitis, for instance, represented a wish to be overtaken by a childhood disease whereby his limbs would wither, so that he would have to be carried and cared for as his father had his mother. The 'withered limbs' phantasy was correlated with self-castrative tendencies, to wit: Let the job on me be finished completely so that I can receive 'total disability' treatment. These feelings returned after he was forced into marriage, and his heroic defences were shattered even further by the depreciatory attitude of his wife, who let him know what she thought of him as a husband and a provider. He had resisted marriage because he apperceptively 'knew' that his defences were too fragile to withstand the vicissitudes of an attachment to another woman.

The analytic work went on successfully. He was able to leave the factory, and he upgraded his position and income. He has found satisfaction in his work as a commercial writer, using his spare time for work on the 'great American novel'. His wife returned, and their family has grown. However, they continue to play a 'cat and mouse' game with one another wherein the wife from time to time threatens to leave because of her feeling of lack of personal fulfilment. He, on the other hand, desires to hold on

and resist a break-up. Still somewhat fearful of passivity, he has been free both of symptoms and the compensatory belligerence which had characterized him.

Discussion

These two patients, from diverse backgrounds, have in common similar ways of dealing with oedipal and pregenital conflicts. There is an intense identification with the mother: (1) to effect denial of sexual urges toward her; (2) to submit to and be taken care of by father; and (3) to deal with the assaults of mother (real and fancied) by being like her (identification with the aggressor).

In both instances the fathers are quite alike in being passive, defeated characters, capable of occasional bouts of rage but no concerted aggressive or assertive behaviour. They were out of the race almost from the beginning, and generally suffered severely at the hands of their wives. There was no chance for oedipal battles between father and son, because the fathers in each instance would not provoke or be provoked. Having already lost their wives to their sons almost from the time of their birth, the competition never had a chance to begin. It was quite evident that, with the birth of the sons, the mothers lost all sexual interest in their husbands. The sons, then, had to bear the consequences of unfought victories. It is understandable that in their adolescence, and thereafter, they were constantly looking for a good fight, as if they would belatedly come to terms with a father who *would* stand up and fight. But later in life the women again enter to recapture the sons and render them womanish.

In the first case the nocturnal emissions were the cause of deep concern to the patient because they represented unopposed incestuous urges. Since father would not fight, and mother was all too willing, perhaps the physician would provide a constraining influence. In the second case the double surgical procedure did represent a constraining force from the outside, and provided a punishment and threat of punishment which may have been an aid to repression. But it also reconfirmed castration fears which played so large a part in his passivity. Then it provided the impetus for the desire to give others the one-two punch.

The vicissitudes of this character structure were apparently known to both Sophocles and Shakespeare. Sophocles' Ajax, often considered the first full-length portrait of a tragic hero in

Western literature, is a paradigm for this problem. In most accounts of Ajax, he is tough, vainglorious, fearless, a man who defies the gods and brings about his own destruction.

Ajax takes little heed of his father's (Telamon) counsel:

'Child,' he said, 'Resolve to win, but always with God's help.'

But Ajax answered with a senseless boast:

'Father, with God's help even a worthless man Could triumph. I propose, without that help, To win my prize of fame.'

(Sophocles, trans. Grene and Lattimore, p. 241.)

Ajax was likewise contemptuous of Athena who stood beside him in the fight urging him on:

To strike the enemy with his deadly hand.

He answered then, that second time, with words

To shudder at, not speak: 'Goddess,' he said,

'Go stand beside the other Greeks; help them.

For where I bide, no enemy will break through.'

(*Ibid.*, p. 242.)

To both his father and Athena he showed little respect, but was boastful and arrogant. He revealed that he had little capacity either to *submit to the advice of others or to learn from them*. Later, jealous, angered, and out for revenge because he was not given Achilles' armour, he set out to destroy the victor, Odysseus, and the Greek high command. As he approached their tents, Pallas Athene rendered him insane and delusional. Instead of decimating his fellow-men, he tortured, mutilated, and slaughtered livestock taken as booty, thinking the animals were the Greek chieftains. As he gradually came out of his trance, he experienced intense humiliation at seeing what a fool he had been. He blamed Athena for her part in changing him and causing his downfall. He was dismayed that on the same battlefield his father, Telamon, had received honours at an earlier date, and that he should suffer such defeat. His father had clearly surpassed him.

'How my father,
Fighting here under Ida long ago,
Won with his sword the loveliest prize of all
For valor, and sweet praise at his return;
But I, his son,
Coming in my turn with a force no less
To this same land of Troy, no less than he a
champion,
Nor less deserving, yet am left an outcast,
Shamed by the Greeks, to perish as I do!'

(*Ibid.*, p. 230.)

The reference to the father winning 'with his sword the loveliest prize of all' is a further indication of the oedipal struggle for the woman (mother). The competing motives of wanting to win, and wanting father to win, are here discernible. Ajax's own wife Tecmessa was spear-won. The prize, Achilles' armour, 'filched' from the hands of Ajax, may represent the phallic oedipal mother. Odysseus, the victor, is clearly the surrogate-father.

He now sees no alternative to suicide, and he now prepares himself. On learning this, his wife Tecmessa pleads with him, fearing for the fate of their son and herself without his protection. He appears to relent, and after reassuring her, falls on his sword. The lines in which he seems to relent have been puzzling to many critics. Some have said that it is the typical cunning of one bent on suicide. By paying lip-service to his wife's pleas, he thereby threw her off the track. Others interpret it as a simple change of heart. Dr Papathomopoulos and I have suggested another interpretation, namely, that he was talking to Athena as well as to his wife, and was bitter at what she had wrought. Athena is indeed the surrogate-mother, as Odysseus, the winner, is his father. These lines are:

Strangely the long and countless drift of time
Brings all things forth from darkness into light,
Then covers them once more. Nothing so
marvellous

That man can say it surely will not be—
Strong oath and iron intent come crashing down.
My mood, which just before was strong and rigid,
No dipped sword more so, now has lost its edge—
My speech is womanish *for this woman's sake*
And pity touches me for wife and child,
Widowed and lost among my enemies.

(*Ibid.*, p. 237.)

Herein is clearly a statement of emasculation: that he has become womanish at the hands of women, notably Athena. 'My mood, which just before was strong and rigid. No dipped sword more so, now has lost its edge. . . . The deflection of his aggression is seen by Ajax as castration.

There are references to Ajax's mother Eriboea. They are descriptions of how she will take the news first of his insane degradation and later of his suicide. Her grief is anticipated as being loud and dramatic. There is more than an intimation of insincerity. Ajax may have learned the defence of reaction formation from her.

'I think, too

Of his mother, with the white of age upon her:
Surely when the news of his mind's ravage
Is brought to her (O lamentable! lamentable!)
Not like the poor lorn nightingale
In a low sob will she utter her heart's anguish,
But high, rending strains will break from her,
The breast be beaten, and the tresses torn."

(*Ibid.*, p. 237.)

Ajax, in preparing for suicide, similarly anticipates that his mother will over-react:

'Poor mother! when she hears this wretched word,
How her grief's note will quaver through the town.'

(*Ibid.*, p. 245.)

These lines about Eriboea are cynical in quality, again emphasizing the son's disdain. Ajax also expresses disgust for his wife Tecmessa:

'And let there be no wailing
Here out of doors; what a plaintive creature
womankind is!'

(*Ibid.*, p. 235.)

Again,

'Woman, a woman's decency is silence.'

(*Ibid.*, p. 224.)

And it is probably the women in his life whom he addresses when he speaks of Athena:

'But the martial goddess, daughter of Zeus,
Cruelly works my ruin.'

(*Ibid.*, p. 228.)

Athena, in the *Iliad*, is no friend of Ajax. In the athletic events she unbalances him so that Odysseus, who prayed for help, wins:

Now as they were in final sprint for the trophy,
There Ajax slipped in his running, for Athena
unbalanced him.

Where dung was scattered on the ground from the
bellowing oxen slaughtered. . . .

And his mouth and nose were filled with the cow
dung. . . .

He stood (Ajax) there holding in his hands the
horn of the field-ox spitting the dung from his
mouth.

And spoke his word to the Argives:

'Oh now! That goddess made me slip on my feet,
who has always stood over Odysseus like a
mother, and taken good care of him.'

(Lattimore [1951], p. 471.)

Athena prevents him from doing the 'masculine act' of seeking vengeance on his enemies. She wishes to save Odysseus and the Greek forces, and as such, Ajax's madness comes as a blessing to the Achaeans. Nevertheless, deprived of his masculine defence, nothing is left but disintegration and death.

Looking to another intuitive poet we find a

similar theme in Shakespeare's *Coriolanus*. The play opens with the defeat of Aufidius by the Roman hero, Caius Marcius, later Coriolanus. They had engaged in numerous battles, and each time Coriolanus was the victor. Returning to Rome after his latest victory, the radiant Coriolanus is made consul, not out of love for him but as a reward for his bravery. However, he shows only contempt for the populace. He will not show humility or mouth the platitudes which people demand. Instead he boasts of his prowess and power. Unable to hide his hatred for the rabble, he is banished from the city by them. Then, when he is ostracized, he joins up with his lifelong rival, Aufidius of the Corioli, to assault and conquer Rome. Rome is defenceless and has no leader to rally its forces. As the victory-assured army approaches Rome, Coriolanus' mother, and his wife and child, go out to him, pleading that he relent in his plans to conquer his native city and to turn it over to its enemies. Coriolanus, after some resistance, succumbs to the pleas and laments of the women and turns back. This starts his downfall. When they return to Corioli, Coriolanus is quickly overpowered and killed by Aufidius.

Early in the play, something of the character of his mother is revealed. Volumnia is a Roman matron whose whole life revolves around the exploits of her son. She is frankly ambitious for him and wants him to take risks in battle. She prided herself on not having her son tied to her apron-strings, candidly revealing her thoughts:

'If my son were my husband, I should freelier rejoice in that absence wherein he won honour than in the embracements of his bed where he showed most love.' [I, iii].

Here she allows herself to identify son with husband, but indicates that she would have him win her on the battlefield rather than in bed. The mother clearly approves of the son's aggressiveness, with the reservation only that it be directed towards external foes of the city. Her husband had succeeded in bed, but this apparently was not enough to gratify her overbearing phallic strivings. In her son, she would have the other gratification. He diligently and successfully fought for himself and for her.

Here we witness the dependent personality, bewildered and paralysed by confusing signals and commands. His destruction represents her final and complete victory over the men in her life. It is she who becomes the saviour of Rome. She is to Rome what Athena was to her city.

When he turned his power against Rome, she stood in his way. She caused him to sheath his sword, rendering him a helpless victim. He became womanish, an easy mark for his old foe. Volumnia knew that her son would be destroyed; that he would have to be sacrificed for the safety of the state. Aggression towards others is acceptable, but not towards one's own people no matter what the grievance.

Speaking to the Coriolians of Coriolanus, Aufidius states:

'You lords and heads o' the state, perfidiously
He has betray'd your business, and given up,
For certain drops of salt, your city Rome—
I say "your city"—to his wife and mother;
Breaking his oath and resolution, like
A twist of rotten silk; never admitting
Counsel o' the war; but at his nurse's tears
He whin'd and roar'd away your victory,
That pages blush'd at him, and men of heart
Look'd wond'ring at each other.' [V, vi.]

Changed from the blustering, prideful hero, Coriolanus is seen again as Aufidius states:

'There was it;—
For which my sinews shall be stretch'd upon him.
At a few drops of women's rheum, which are
As cheap as lies, he sold the blood and labour
Of our great action: therefore shall he die,
And I'll renew me in his fall.—But, hark!' [V, vi.]

These are statements reflecting his new passivity, his feminization, which leads to his destruction at the hand of his foe who never before could lay a hand on him.

One readily sees the similarities in the characters of Ajax and Coriolanus. These are men who remained attached to their mothers, never fought out their oedipal battles with their fathers, and developed tremendous reaction formations of implacable belligerence as a defence against their feminine identification, which, when it returns from repression, results in their destruction. Coriolanus, like Ajax, is destroyed after agreeing to listen to the pleas of his mother and his wife and son. It is thus that the 'long drift of time brings forth from darkness (unconscious) into light' and cannot be tolerated.

Coriolanus is killed by his lifelong enemy (father-surrogate) whom he had repeatedly defeated in battle until he became 'womanish' by the pleas of his mother. He then passively succumbs to Aufidius, his former enemy. Ajax's parents are represented by Athena and Odysseus.

Odysseus and Aufidius are similarly magnanimous toward the hero after he is slain.²

We recall Ajax's fight with Hector. Like Jacob and the angel, there is neither victim nor victor. Jacob receives the blessings of the angel; Hector rewards his adversary with his own sword. It is with this weapon that Ajax later commits suicide on enemy soil after he is deprived of Achilles' armour by the Greek high command. Ajax is thus given by his foe the sword that he did not particularly seek, but was denied by his friends the Achillean armour, symbol of leadership, for which he desperately longed. This promotes an attitude of cynicism, i.e. look to your foe for your reward and unfair treatment at the hands of your friends! Injury from one's kinsman, real or imagined, produces a particularly painful wound that provokes inexorable impulses for revenge. And yet it is not in the order of things that such impulses be fulfilled. In the *Iliad* we find when Achilles, flushed with rage, is about to assail his compatriot, Agamemnon, with his sword, Athena catches him 'by the fair hair' and causes him to desist. 'I have come from the sky to put an end to your *menos* (passionate impulse)' (Lattimore, 1951, p. 64). Similarly, Ajax was unable to gain revenge against the Greek chieftains. He was driven mad and his sword deflected to animals just as Jehovah protected Isaac from Abraham's knife. Their aggression was spent on a scapegoat. The lesson must be learned again and again that one cannot kill one's own, no matter what the provocation. This is the parricide barrier that must not be transgressed even at the expense of one's sanity. One can, however, strike out against the common foe, not only with impunity, but with the prospect of great rewards. Achilles' humiliating revenge on Hector for the death of Patroclus is acceptable, although desecration of Hector's body was prevented. Achilles in his rage threatened to feed Hector's body to the dogs after he had caused it to be torn apart by dragging it behind his chariot. The gods wanted to prevent this desecration. Aphrodite drove the dogs back day and night and anointed the body with 'rosy immortal oil' so that it could not be torn. Phoibos Apollo brought down a darkening mist about the body from the sky to keep the force of the sun from causing it to wither away (Lattimore, 1951, p. 455). Finally, Achilles was persuaded to give up the body for burial to

² The author is indebted to the editors of the *Psychoanalytic Quarterly* for pointing out the similarity of the characters of Ajax and Coriolanus in 'Sophocles' Ajax:

A Morality for Madness,' *Psychoanalytic Quarterly*, 30, p. 410, by the present author and E. Papathomopoulos.

Hector's aged father, Priam. Similarly, both Ajax and Coriolanus are accorded proper burial by their foes.

We saw that Coriolanus, having been ostracized by his own city, joined with the enemy to seek revenge against it. Coriolanus was given the name of the enemy city because he had been successful against it. The city of his enemies, not his native Rome, was the scene of his great victories. Just as Ajax received his sword from Hector, Coriolanus received his very name from the enemy. In each instance, an identification with the enemy took place and kinsmen became objects of aggression.

Ajax and Coriolanus were encouraged and acclaimed, as warriors must be, when their aggressiveness is directed towards the destruction of the enemies of the commonwealth. Their personal actions are consonant with the values of the group. These two warriors, however, were no longer able to direct their hostility towards the acceptable enemy. The pressure for revenge (parricidal impulse) became so great, that aggression toward the external common foe no longer sufficed. The sword had to be turned against 'the family'. We see here a breakdown of the defence of displacement. It is as if the individual can no longer be satisfied with slaying enemies. His impulses carry him relentlessly toward the tabooed objects, his kinsmen. Both are destroyed because they showed their hands.

As critics have noted, Ajax's madness really anteceded Athena's intervention. His reaction of intransigent rage after his loss to Odysseus gave evidence of the beginning of the disintegrative process. Coriolanus' incorrigibility in dealing politically with the populace of Rome betrayed a striking lack of compassion as well as adaptiveness. Aggressiveness seemed unopposed within him, and the line between friend and foe obfuscated. The feminine superego cannot tolerate aggression toward the family. The aggressor, confronted by threats of the superego, backs away and becomes passive, feminine. His aggression is turned against himself. With Ajax it is suicide with Hector's sword; Coriolanus allows his old foe to do him in. In both instances there occurs a passive surrender shortly after an act of violent transgression is planned but thwarted. This is consonant with psychoanalytic theory that self-destructiveness is an attempt to rid oneself of superego pressure (Fenichel, 1945).

In Plutarch's account of Coriolanus, Volumnia succeeds in stopping her son's onslaught by

invoking the claim of a debt to her as a mother. 'You have punished your country already; you have not paid your debt to me.' Having said this, she threw herself at his feet. After he succumbs to her pleas, he replies prophetically: 'You have gained a victory, fortunate enough for the Romans, but destructive to your son; whom you, though none else, have defeated' (Plutarch, ed. Davidow, p. 125).

What is the debt owed by Coriolanus to his mother? Why can he no longer go on towards his goal when she falls at his feet? We cannot miss the implication that she holds him responsible for her castration. In falling to the ground she reveals to him her absence of structure. She cannot remain erect, for he has destroyed her own phallic strivings. The body as penis is now limp. Here the castration complex of the woman shows a shift from mother as castrator to son as castrator. Her genitals (phallus) were destroyed with the birth of the son. The grievance is now against her son instead of her own mother. He is beholden to her for having 'so weakened' her. The firstborn son who 'splits' the mother's womb ends the expectations of the emergence of a penis of her own. Spurgeon (1958, p. 347) calls our attention to the imagery of Shakespeare's Coriolanus which relates to the body and bodily ills. Coriolanus himself is represented by the tribunes as a 'violent disease which spreads infection which must be cut away'. Coriolanus' action toward Rome is described by his mother as 'tearing his country's bowels out'. Coriolanus is seen as the grand inquisitor of his birthplace. He must repay his mother with his own life for the damage that he has done her. He is a disease that did injury to its host and must repent. In leaving her body, Coriolanus took his mother's strength with him. He is her roving penis. Menenius argues that Coriolanus is a 'diseased limb, a gangrened foot' (Spurgeon, 1958, p. 348). He is a member that has become detached from its blood supply.

Adamant against all other appeals, he cannot resist the demands of his mother. He goes to a certain doom rather than defy her. Again, superego pressures appear to pre-empt preservation of the self. In the instances of Coriolanus and Ajax perhaps the warriors succumb to the mother-god power that comes not only of superego influence but also out of the pre-cognitive era of mother-child unity, as in Maloney's (1954) formulation in regard to theophany. Coriolanus and Ajax both are

reduced to a state of helplessness by mother power; a reduction that no one else could affect.

Summary

The intuitive insight of the poets is again illustrated in Sophocles' *Ajax* and Shakespeare's *Coriolanus*. Both of these characters are accurate models for a type met with in clinical practice. Two persons in psycho-analytic therapy are described, showing the breakdown of a 'masculine protest' or hyper-masculinity defence under the pressure of feminine influence. Here, preconscious factors, promotive of timidity and

docility, proved disastrous to these vulnerable men. Their prototypes were easily recognized in *Ajax* and *Coriolanus*. The genius of the poets is particularly striking in their awareness of the vicissitudes as well as many aspects of the genesis of this character type. It comes as no surprise that Freud gave full credit and priority to the poets and philosophers for the discovery of the unconscious:

Strangely the long and countless drift of time
Brings all things forth from darkness into light,
Then covers them once more.
(Sophocles, trans. Grene and Lattimore, p. 237.)

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A CONTRIBUTION TO THE METAPSYCHOLOGY OF CYCLOTHYMIC STATES

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A considerable body of knowledge has been built up on the metapsychology of cyclothymic states, in both the symptomatic (manic-depressive psychosis) and characterologic (cyclothymic character) forms through the contributions of Freud, Abraham, Klein, Lewin, Helene Deutsch, Fenichel and Schilder, to mention only a few of the major investigators who have taken a special interest in this area.

A review of their writing leaves little doubt that there is a substantial area of agreement at least on the following points: (i) that mania and melancholia are intimately related metapsychologically; (ii) that they are related to normal states of mourning and elation; (iii) that some regression to narcissism is involved; (iv) that they have a fixation point somewhere during the phase of transition from part to whole-object relationships; and (v) that the fixation point represents difficulty at the developmental phase centring upon inability to preserve a good object internally because of a tendency to denigrate it and triumph over it.

This paper aims at amplifying this knowledge by demonstrating the specific nature of the defect in the relationship to the good object that weakens the capacity for preservation and, associated with this, to demonstrate the nature of the periodic regression from the more integrated obsessional organization which the cyclothyme manifests. An attempt will also be made to show the link between these processes and the confusion and flux in the bisexuality which is so prominent in these patients. By demonstrating this particular clinical problem, it will be seen that a contribution is made to the broader theoretical problems of mood and hope as well.

The following order will be followed in the presentation: (i) outline of the psycho-analytical theory of manic-depressive states with emphasis on the conception of mania in Klein's work,

indicating the degree of agreement or disagreement with other major investigators; (ii) description of the metapsychological contribution which this paper seeks to make; (iii) demonstration of these concepts in action in a crucial phase of the analysis of a cyclothymic personality; (iv) discussion of the implications of these findings for the broad theoretical problems of mood, hope, and differentiation of the bisexuality.

Present Status of the Theory of Cyclothymia

In this brief review special stress will be laid on the vicissitudes of the internal object relationships. The foundations of our metapsychological interpretation of cyclothymia go back to Abraham's 1911 paper, amplified in 1924 following Freud's 1917 and 1921 papers. Already in these early times the inability of the cyclothyme to preserve his good object internally was recognized by both authors; the tendency to denigrate it and triumph over it, to expel it and reintroject it, to identify with it in its denigrated state as well as assailing it as an internal object—all these processes were observed by them both. The roles of oral and anal sadism, of regression to part-object relationships and to an increased narcissism, play a part in both conceptions. But Freud suggests more clearly that a fusion with the ego ideal in mania and identification with a denigrated superego in melancholia are the chief differentiating factors. Neither, however, clearly linked it with the Oedipus conflict. The nature of the process of 'fusion' is not clarified by Freud, nor does his analysis indicate that the superego of melancholia and the ego-ideal of mania may be different objects within the same structural area of the mental apparatus.

These ambiguities are later resolved by Klein's theory of manic-depressive states, based as it is on a more detailed theory of the early superego which she recognized as consisting of a multi-

plicity of part objects, good and bad, related to maternal and paternal introjects.

The early theories of Freud and Abraham also encompassed the relation between the character structure in obsessional states and cyclothymic states. Abraham in his early paper had already recognized that the remissions in manic-depressive states are characterized by the predominance of obsessional organization and defences in the object relationships. He emphasized the preservation of a relationship to a good internal object, recognizing that it was far from a happy and free relationship and far from a completely benign good object. Abraham saw the role of increased oral *sadism* as being a *consequence* of the regression into the cyclothymic state, and equated narcissism with the cannibalistic modes of introjection predominant in cyclothymia. In neither his nor Freud's work at that time is the *regression* seen as the *consequence* of anxiety due to sadistic attacks on the object, but rather, in keeping with libido theory, they view it as being due to a greed for new objects, carried out by cannibalistic means (narcissistic incorporation), which is not seen as necessarily sadistic.

This area of theory, the relationship of cyclothymia to obsessional states and the factors making for progression and regression between them, as well as the overall relationship to the developmental phases of infancy and childhood, has not been dealt with by other writers on mania and melancholia until the work of Klein (1935).

The connexion of these problems with early infancy and particularly with the relation with the breast was stressed early by Rado (1928) and Helene Deutsch (1928) with special reference to the affects of elation and ecstasy, but the differentiation between an internal and an external breast was not made by these authors. Lewin (1932) on the other hand links hypomania with sleep and his own theories of the 'dream screen' and the 'oral triad', but speaks also of an identification with the parents in coitus. However, his material seems to show that the patient identified with a very bad, denigrated and rather lifeless coitus between internal parents. He also adds to the theory of mania the important role of denial, later (1933) confirmed by Helene Deutsch. In Klein's work this mechanism achieved a deserved prominence and was clarified as to content, namely, the denial of psychic reality, i.e. of the existence or importance of the internal world and its objects.

Helene Deutsch was the first writer to bring

oral envy into prominence in the theory of mania, although Lewin suggests that the identification with parental coitus has a basis in envy. This area too has been greatly elaborated in the work of Klein (1957) but not specifically linked back in detail by her to the earlier description of the processes of denigration of the primal good internal object, the breast, which precipitates the manic attack.

Klein's theory of the cyclothymic states is bound up with her conception of the transition in ego development from the paranoid-schizoid to the depressive position, characterized by the emergence of the whole-object relationship and love of a unique and irreplaceable object. With these changes there occurs an adaptation of the defences characterizing the early period, and their employment against persecutory anxiety. In the depressive position they are deployed in modified form against the spectrum of depressive anxieties. Thus splitting, projection, introjection, idealization, and omnipotent control find a new role in relation to the damaged and undamaged objects, internal and external. Added to these, to make up the full equipment of the manic defences, are denial of psychic reality and denigration of the object. She stresses the role of these manic defences in both the modulation and the preservation of normal development, as well as their excessive and destructive employment in pathological processes. This differentiation is primarily a quantitative one, depending on the balance between the loving and destructive forces and the degree to which envy and jealousy have been moderated in relation to a good object. But she states clearly that the basis for the fixation point for later cyclothymia is a qualitative one, founded on a *pathological* development at the onset of the depressive position, where Freud, and Abraham in particular, were more inclined to see a fixation to a normal but intensified phase of libidinal development.

Certain more recent work will be discussed after the clinical material has been presented.

Before passing on to the next section, it may be worthwhile to comment on the methodological problems that lie behind some of the disagreement among various investigators. The greatest areas of disagreement seem to centre about the nature of the anxiety situation being defended against and the specific mechanisms of the manic reaction. The impression is unmistakable, though not always clear in the clinical material cited, that either florid manic

reactions have been briefly analysed (Katan, Schilder), or brief hypomanic states have been seen during the analyses of patients of varying diagnosis (Lewin, Fenichel, Deutsch, Angel). The former situation is open to the suspicion that the efflorescence of the manic state has been seen, but not the manic reaction *in statu nascendi*; while in the latter, the workings of manic mechanisms over a wide spectrum of anxiety situations not specific to cyclothymia have been studied.

While the general conclusion of this paper has been drawn from a variety of clinical experiences, a single case will be demonstrated in detail. The diagnosis of cyclothymic personality will be documented both historically and by the nature of the transference process. Then in clinical material the specific process underlying the patient's repeated loss of the obsessional adjustment and regression back into hypomania will be demonstrated in the repeated progression and regression in the transference during a crucial period in the analysis.

The Metapsychological Contribution of this Paper

It is sought here to extend the psycho-analytic theory of cyclothymia in one direction only, to clarify the nature of the internal object relationships which underlie the tendency to regress from the obsessional organization to the hypomanic situation. This latter state sets the stage for those further denigrating and expulsive attacks on the good internal object which may end, unless checked, in melancholia, may progress to paranoia, or may even give way to a full-blown acute schizophrenic catastrophe.

In the clinical material, the following thesis will be illustrated: the cyclothyme is characterized by a tendency, under psychological or physiological stress, to turn against his good internal object, fundamentally the breast of the internal mother, in his unconscious infantile relationships. This turning against the breast takes the characteristic form of an intensification of oral greed which has the aim of violently removing a structure integral to the breast, felt to be penis-like, co-extensive with the nipple, and the source of strength, creativity, and judgement in the breast and mother. This breast-penis, because it cannot be retained after being stolen from the breast without becoming highly persecutory, is then projected into the father's penis, which thereby becomes enhanced and idealized, and an object of greed at all levels and zones. The breast, now reduced to the status

of a passive container, is open to further attacks since love and admiration for it have been greatly diminished. This internal constellation is the basis of hypomania, the first step in regression from the obsessional organization.

The driving force in this attack on the breast is the unintegrated primal envy. The forces unleashing the envious attack may be various, at different times and in different patients. The character manifestations of this tendency are: (i) an instability in sexual identification and a confusion between masculine and feminine taking the form of an exaggeration of strong = active = masculine, and weak = passive = feminine; (ii) pervasive pessimism about the value of life and the richness of its joys.

The restoration of the damaged internal breast can either be brought about by a good intercourse between the internal parents or by a good feed at the external breast (or a later transference representative, as for instance the analyst's mind). But these restoring processes are resisted because of the renewal of oedipal tensions and the pains of the depressive anxieties which accompany them.

The Patient

At the outset of treatment, the patient presented herself as a small and slim, rather bow-legged and pigeon-toed woman looking somewhat younger than her 35 years, tastelessly dressed, with a slightly mannish quality. This impression was enhanced by the lack of make-up, other than a little lipstick, and the short, straight boyish haircut. Her pleasant features were unexpressive of feeling, eyes always averted, posture rather angular and drawn inward. But her voice with its soft European accent suggested in its timbre both intelligence and a capacity for feeling, while a little gasping mode of showing assent, with its tic-like quality, gave the impression of continual inner anxiety.

At that time she was in the second three-month period of her third pregnancy, and was on leave of absence from her professional position, staying at home to care for her second child, a boy of 18 months. She had lost her first boy in infancy owing to asthma, probably cardiac in nature based on congenital heart defect. Her husband was described as very English and a good skilled worker, a rather passive man of whom she was fond but on whom she could not rely emotionally or financially. Their satisfactory standard of living was due largely to her good income and, in order to maintain it, she had to return to work once the new baby was weaned.

Her circumstances, she felt, were adequate to a happy life, but her illness made it a torment. She could not show affection for her son and was in

constant dread of disturbing his mind with obsessional thoughts of his genital. She could not cook a meal without a fear that she had put something poisonous into it; could not go to sleep without hours of ritualistic checking of gas and water taps, doors, windows, and light switches. Her relationship to her husband was one in which he was felt as a burden, and even then their intercourse was managed by her to provide him with pleasure, for he was rather impotent, especially as to orgasm. Her own genital seemed greedy, and her orgasm came easily and was indistinguishable to her from a masturbatory climax. A depressed mood was always the sequel to coitus. She was a slave to her house, isolated from her neighbours, and felt herself an unwanted foreigner, persecuted by the English weather and shopkeepers.

But her health was good, her body bursting with vigour, and her mind always active, planning and carrying out plans, despite the enveloping pessimism through which the world was seen as a true hell, or perhaps at best a purgatory. She secretly, with her own mixture of superstition and Christian dogma, looked forward to deliverance through death, and would often, in the midst of her rituals, ask God when her release would come.

Almost lifelong hay fever and eczema of hands and trunk added physical discomforts which she experienced almost as a relief of the mental suffering. She could fight back with scratching the itch, rubbing the eyes, blowing the rebellious nose.

While she looked forward to the new baby and yearned for a little girl, she was terrified at the prospect of looking after it. The conviction that she had caused her first child to develop asthma because of her thoughts of his genital made her feel incapable of keeping her babies alive. She arranged for her mother to come from her native land to help for the first few months and for a nanny to take over after that, so that she could return to work after the weaning. She loved her work and was eager to return to it.

Her mental status at the initial interview gave no cause for alarm. She was oriented, presented a lucid history with insight into the mental nature of her symptomatology, gave no evidence of grossly impaired reality sense or of bizarre mental content or phenomena. She was clearly an intelligent woman and very well motivated for treatment.

History

The childhood of the patient, the sixth child of seven of a professional couple, was spent in a small city of northern Europe. The mother, who had been the eldest of her own large group of siblings, had been surrogate mother to the others from the age of 12, when her own mother had died. Subject to depressed periods as well as periods of intense extramural activity with women's organizations, she was nonetheless the stabilizing influence of the

family. The father was a handsome and sociable person, vain in his status in the community and accustomed to pampering at home by wife and daughters. While he was too easily seduced by flattery, and intemperate in his outbursts when thwarted or hurt, his goodness showed itself in a generosity that was apparently boundless, if not always judicious. But neither parent seems to have been deeply sensitive to emotional problems. Both maintained a mixture of superstition and Oxford Movement optimism in relation to the mysteries of life.

The household was a lively, well ordered, and comfortable place, a favourite haunt of friends both of the children and the parents. The one son of the seven children, five years older than the patient, was an object of concern to parents and sisters alike owing to his passivity, artistic interests, and laziness. In contrast, the patient's many serious difficulties, primarily internal and secret, passed relatively unnoticed until adolescence.

There were no known complications in the pregnancy or delivery except that the pregnancy was undesired and the mother was in a mild depressed state. Breast feeding continued until close to one year despite several complications. The first of these was extremely early teething, apparently of both upper and lower incisors, by three months. To complicate this the infant developed severe whooping cough with measles at three months and was given up for dead by the doctor. Devoted nursing by the mother, which included such measures as manual removal of pharyngeal secretions, alternate exposure of the child to heat and cold, and frequent suckling, brought recovery after a three-week period of acute illness, leaving the mother in a severely exhausted state and the child emaciated.

The birth having taken place in the winter months, this illness must have occurred in very early spring. All the next summer was spent by the parents building a summer cottage a few miles from town, taking the patient with them in her Karicot. This cottage subsequently became an object of great attachment for the patient.

Weaning from the breast before the end of the first year was preceded by the commencement of toilet training with the use of paper suppository stimulation. The baby's response was in the direction of compliance, independence, ambition, and a turning from the mother towards an intense flirtation with the father, which seems to have had encouragement from both parents. Most of the first year had been spent in the parental bedroom.

The two years from the beginning of walking to the birth of the baby sister were ones of 'bliss'; she was a great entertainer, pretty, flirtatious, greedy for the limelight. This hypomanic period was not disturbed on the surface by either the appearance for six months of a godchild whom the mother cared for following on its mother's death, nor did the mother's

pregnancy itself break through this elated period. Her relationships at that time were universally 'good': that is, she was on good terms with mother who was treated like a devoted and respected servant. Her life revolved around father and already by the age of 2½ she was toddling down the hill from home carrying his lunch to him in a little basket, ushered across the street by his assistant, treated like visiting royalty by his office staff and clients, rewarded by him with a kiss and money to buy a banana at the fruit shop downstairs.

She was the darling of her sisters and brother. Even the next older by three years, the sweetest by nature of the family, doted on her. But for her demands to be thwarted was unbearable, felt as an affront, and dealt with by high-handedness—particularly by stealing without guilt—taking what was her due.

The birth of the baby sister shattered this little paradise, and the patient vividly remembers her despair and rage at finding her mother's bedroom door closed to her. Unfortunately the following year, while the patient struggled with bitterness, oscillating between tantrums and over-solicitude for the baby, family affairs turned for the worse and ushered in a prolonged period of marital conflict for the parents. Within a short period the father lost his savings and more in a maritime investment, mother had a miscarriage, the home had to be sold and replaced by a smaller and less elegant one, servants were reduced in number, and in the midst of this the patient was sent away for a month to stay with a former maid and chauffeur.

It was from this separation, consciously felt as a banishment, that she returned to the family a chastened, neurotic, and depressed child. Thus by the age of 4 she manifested an unwholesome character distinguished by secrecy, an outward docility and helpfulness towards mother, mounting fastidiousness in her food habits, competitiveness with the older children, and preoccupation with her own, her mother's and baby sister's health.

During the next six years, family life was considerably disrupted by father being mildly alcoholic, inattentive to mother, and unreliable at work. The patient's character disturbance seemed to fall in with mother's needs, for she became the companion of mother's loneliness, often sharing the bed until father came home late at night, partly drunk. At school she was the same, with consequent mediocre accomplishment and a poverty of imagination. External reality seemed in many ways to coincide with internal reality and thus, as we shall see, greatly strengthened certain defences.

But this picture of a joyless, obsessional little prig was done away with quite suddenly by a tonsillectomy at the age of 10. In its place appeared a very tomboyish exuberance, increased imaginativeness, and improved learning capacity, competitiveness in sport, and contempt for femininity. Again her father

became the centre of her life. A dream from age 11 illustrating this renewed hypomanic state has always stood out in her memory. It illustrates the identification with the father which replaced the earlier flirtation. In it she was standing proud and triumphant on a pile of dead bodies of thieves and murderers who had invaded her room.

Skiing in the winter with father, fishing in the summer with father, everything revolved around gaining his attributes and his admiration. The onset of menses swept back into consciousness the sexual excitement in father's presence, spoiled her pleasure in his company, and brought the return of compulsive symptoms, now in the form of compulsive urination at night, checking doors, switches, and taps. Depressive elements were intensified by mother having another miscarriage when the patient was aged 12. By 14 she had insomnia, was hypochondriacal about her internal genitalia and breasts, and fearful lest she should grow a penis as a result of masturbation, an anxiety which became prominent later during her first pregnancy.

Thus as an adolescent she was shy, preoccupied with school work and her ambition to be a doctor or a dentist. But she was discouraged in this by her father because of her anxieties and hypochondria. After a brief period teaching in school before war began, she entered training for her profession. Her first love affair at age 19 led to intercourse with great pleasure but without orgasm. This relationship was rather sabotaged by the family and its collapse ushered in a period of compulsive masturbation, feelings of persecution at the hands of her superiors at work, insomnia, fatigue, confusion, depression, and suicidal plans, from which she was saved only by her mother's unexpected arrival. (This type of acute illness was repeated at 22, when she was training again for a higher qualification in her profession, but was more hypochondriacal in structure and attributed by her to mercury poisoning. She rescued herself by a long holiday skiing.)

During the war and the Nazi occupation she worked away from home and gradually began to hold together an obsessional pattern, broken periodically by hypochondria, periods of social and sexual excesses, and periods of depression. When her father became terminally ill with carcinoma of the lung, she nursed him devotedly but without a feeling of love, for her ambivalence to him had been conscious all through the period of the war, thinking of him at one moment as secretly the leader of the underground and the next moment accusing him in her mind of being a coward and food hoarder.

His death brought in her most severe period of social and sexual excesses, this time with drinking, but she settled back into a more obsessional pattern, reinforced by the nature of her work. Hopes of marriage and children were more or less abandoned, until she met her husband after coming rather impulsively to work in England. He proved to be

the first man with whom she found sexual satisfaction. A marked elation replaced her now chronic obsessional pattern as a result of the pregnancy that resulted from their premarital relations, and she then realized to what an extent she had abandoned all hope of ever having children. In her joy, she was relatively unconcerned about whether the father of the child would marry her, which he in fact was eager to do.

This brief respite from symptoms, a period of 'bliss' covering the first six months of the pregnancy, was shattered abruptly thereafter with the appearance of the ruminative dread that she would harm her child by staring at it. She collapsed into a depressed and agitated state, at which time she was first referred by her general practitioner for analysis. This was in April 1952. By the time treatment could be offered 15 months later, she had lost the first baby at about 9 months of age and was again pregnant, living temporarily abroad, at home with her mother. She returned to England in a dreadful state of anxiety after the birth of this second little boy. Treatment was started five months later, in May 1955, at which time she was again pregnant, urgently wanting to begin her treatment before the birth of the child.

The Analytic Process

The analytic process during the next six years can be divided with fair accuracy into six periods, the fourth of which will be the focal point for this paper. The first period, covering the last months of her third pregnancy and the four months of her breast feeding of the new baby, was characterized by idealization of the analysis.

Two transference patterns were reflected in the dreams and behaviour, one in which the analyst was an ideal mother and her husband a persecuting father; the other in which the analyst was a persecutory mother and her husband a father who offered her an ideal penis. These two patterns oscillated with each week-end, bill, and holiday.

The second period of analysis followed the collapse of her breast feeding under the pressure both of anxieties about being harmed by a greedy and hostile baby and fears of harming it by feeding it bad milk and worse thoughts.

The year that followed was dominated by the gradual revelation of her ambivalence to the mother-analyst, defended against tooth and nail by acting out which strikingly repeated the latency years in which she had been the companion of mother's unhappiness owing to father's drinking and indifference. This was tirelessly and secretly acted out by a slavish faithfulness to the drudgery of analysis and her job, accompanied by endless cleaning and decorating of her home. All disappointments or persecutory feelings towards the analyst-mother were experienced and acted out with shopkeepers and bus conductors.

The repeated analysis of the disruptions of this pattern caused by week-ends, holidays, bills, and other chance occurrences gradually brought a third and more obsessional structure into the transference, in which ambivalence to both parental figures was reflected, the bad relations being acted in the transference and the good ones with her home, work, children, and husband. The disappointments and disruptions during this period, which lasted for about a year, led more clearly to internal attacks with hypochondriacal and depressive consequences on the one hand, while on the other they were gradually more and more strongly defended against by a rigid control over the analyst-parents internally, reflected in a florid and migrating obsessional and compulsive symptomatology.

This third period finally gave way to a fourth, occupied with the analysis of her oral greed and envy, and dominated symptomatically by hypochondria gradually yielding more and more to periods of depression and periods of marked clinical improvement.

The fifth period, starting roughly in the spring of 1959, was occupied with a renewed working over of her oedipal conflict, more now on the genital level and more clearly bisexual in its structure. This period was characterized by characterologic and symptomatic improvement, a deepening of her attachment to the analyst as a person, and the great lessening of her acting out, with consequent improvement in all her outside relationships. The sixth period, termination, is still in progress.

To return now to this fourth period of the analysis.

By Christmas 1957 the strong maternal transference, dominated by oral greed and possessive jealousy, was recognized by the patient. The hypocrisis of the obsessional isolation of the internal mother and of its external counterpart in the begrudging attitudes towards the analyst in respect to money, week-ends, holidays, professional success, other patients, etc., was well understood. A strong contact with her own phallic masculinity kept coming through at times, but still too fraught with guilt to be long tolerated, usually promptly projected into her husband or her little boy. These insights were accompanied by acknowledgement of clinical improvement, particularly in relation to her ability to make contact with her children, her pleasure in her home and work, a lessening of her compulsions, and a decrease in her characteristic pessimism. Her relationship to her husband, however, was decidedly worse. The passing of this Christmas holiday of 1957 marked the beginning of the slow and repetitive process which I wish to emphasize in this paper as the central problem in the patient's analysis, namely, the restoration of the qualities of strength, judgment, and creativity to her internal mother and the reintegration of a part of her own personality containing the destructive oral envy towards the mother and her breast.

Signs of envy and a wish to steal or spoil appeared first in material and behaviour referable to the paternal transference. The oral nature of the greed was clarified. For instance, she reported that, after a refusal of coitus by her husband, she had angrily gone into the children's room to sleep where she found herself getting into a rage with the analyst. Then she suddenly fell asleep and dreamed of a man in a short nightshirt, but instead of a penis he had a stick of butter for a genital. It could be established that her wish for coitus with her husband had derived partly from an infantile wish, split off from the transference, to steal by eating up with her mouth-genital this idealized butter-penis. But once she had it inside her, it changed to a persecuting urine-penis which forced her to urinate continually. This could be demonstrated in a dream in which she passed a man holding a tray of dental instruments. Then one of them was in her hand and she instantly had the urge to urinate. But on the toilet, her urine flowed endlessly.

She clung to a particular claim as the bulwark against feelings of guilt about this greedy stealing from her internal object and its external manifestation in the transference of ingratitude, begrudging of payment, and indifference to the analyst's convenience or welfare. This claim was that the good things derived from the analysis were not for herself but for her home and children. This hypocrisy was acted out for months in which she flaunted with long sighs her joyless submission to the analysis, while she would happily run home afterward, reporting the following day the joys of staying up into the small hours decorating, sewing, planning treats for the children. If it occurred to her that these joys were in any way manifestations of improvement in her mental health, she promptly thanked God.

What seemed to be an impenetrable defence could only be broken through when I could show her that it was not from the father that this stealing occurred but from the mother. She dreamed that she was in a dingy, cheap café with a new baby in a Karicot. She felt that God had miraculously given it to her and thanked him in silent prayer. But before her eyes the baby changed, first into twin babies and then into the twin breasts of a pretty young woman. Here I could show her that the analysis was felt as a gift for herself, but that the distortion consisted in confusing both the source and nature of the gift, representing it as a baby obtained from the idealized father (God) while the relationship to mother and breast was denigrated (the dingy cheap café). But the dream goes on to acknowledge the recent recognition that she is the baby and the gift is of an internal mother and her breast, which could only come from good feeds in the analysis from the analyst as a mother. The immediate reaction to this interpretation was an experience of pleasure, the expression of gratitude, and recollection of quiet talks with her mother over coffee in early adult life. But the next day a very

violent negative therapeutic reaction ensued; she was in despair and the analysis was worthless.

This pattern of negative therapeutic reaction to particularly fruitful, relieving, or enjoyable sessions became more and more the rule, and, parallel to it, with the passing of the summer holiday of 1957, the maternal transference pressed more and more to the fore. Her hypochondria now took the form of migratory pains with associated phobia of cancer. Her former habit of taking abortifacient tablets prior to her menses returned, and with it a galaxy of fears for the safety of her children in the home. On the other hand she reported that she now spent more time and derived more pleasure from being with the children, feeding, playing, or teaching, and less time on the house itself, cleaning or decorating. The hypochondriacal symptoms now worsened every week-end, and the acting out of these fears with her children representing the babies attacked inside the mother caused her to miss almost every Friday session for months.

I was gradually able to demonstrate to her how the neglect of the analysis during this acting out worked in a circular fashion with the negative therapeutic reactions to cause the analytic mother externally to become damaged in the patient's mind and then neglected because of her loss of value; that this resulted in parallel changes in her internal situation; that she defended against her guilt through acting out her identification with this mother who was greedily eaten into (the hypochondria and cancer phobia), neglected (her now nearly complete sexual incompatibility with her husband) and enviously attacked should she become pregnant (the taking of abortifacient tablets), attacks which were too protean to be defended against (the galaxy of fears for the safety of the children inside the house).

But each painful contact with the guilt and feelings of worthlessness inherent in the process of reintegration of this infantile destructive greed was quickly recoiled from. The responsibility would be projected onto the internal father, then externalized to her husband whom she was able, unfortunately, to provoke into tantrums and threats to murder the patient, the children, or himself. Bringing the situation back into the transference through interpretation would diminish the acting out and bring improvement to the health and relationship of the internal parents. Then the obsessional defences would be invoked once more to prevent the coitus of these internal objects and would be acted out as various compulsive rituals of checking and obsessional suspicions about the sexual activities of the children, or her husband, or the husband with the children.

In turn, analysis of the transference and the internal situation underlying these symptomatic attitudes and activities would bring her relief, renewed contact with depressive feelings, renewed reparative efforts and a new explosion of destructive

envy. Typically at this latter point she would dream of a happy, wealthy, attractive couple with one child. In a few days all would be a shambles in her dreams, a burnt-out ship, or a bombed quayside with war orphans, or an Italian slum flat with an apathetic couple and a dead child.

A particular échelon of defence against the guilt about the attacks was discovered to be in the form of a secret accusation that the envy which motivated these attacks was in the first instance projected into her by the analyst. She dreamed of entering a little shop to order some whipped butter, but when the shopkeeper whipped it before her eyes, she angrily accused him of making it dirty. She demanded that he give it to her as heavy cream and she would whip it herself at home. It was possible to show her how she resisted any experience of admiration for the analyst's mind as a creative analytic breast, trying to force him to go along with the pretence that it was a passive organ which simply delivered its goods derived from books and teachers to whom the creativity was attributed (father) or that it delivered the raw materials which she creatively whipped into shape in her mind.

To summarize briefly: by the time the 1958 summer break was nearing, the patient had reached a point where her envy, with its characteristic modes of operating both internally and externally in the transference, was well known to the patient and recognized as being directed toward the mother (and particularly the breast) as well as the father (and particularly the penis). But the admired and envied capacity for creativity still remained split between these two on the part-object level, with the qualities of wealth, generosity, and warmth delegated to the breast as a *container* and those of strength, endurance, and judgement allocated to the penis of the father as a *performer*. Although I had shown her evidence many times, she seemed unconvinced both consciously and in the depths that the obsessional control over and separation of her internal parents, and the consequent symptomatic eruptions of each week-end, were directed at preventing a coitus which not only was *hated* as the source of a rival baby who would push her out, but *feared* as an act which, by restoring the internal penis of the mother and breast, and thus by restoring the full love and admiration, might also precipitate an all-out envious decimation of the good object which would be irreparable (madness).

By the time the summer break arrived in 1958, the positive maternal attachment was so intense and the separation anxiety so great that a flight to her mother similar to one during the second summer break of the analysis took place, but with only temporary relief of her fears of some disaster overtaking the analyst while he was away. This flight was very different from the earlier one, which had been completely hypomanic in mood. The current journey was undertaken with considerable insight that she

felt unable to bear six weeks without a mother-person. Much of the anxiety about the analyst's welfare and safety was at first split off onto her husband, who manifested a very suicidal attitude in fact about her going and was afraid she would not return to him. However, the anxieties could be brought back into the transference through interpretation. This resulted in a softening of her subtly provocative attitude toward her husband, so that she finally arranged for him to join her for the last two weeks of the holiday.

The work of the first two weeks in September 1958 illustrates in a rather condensed fashion the previous year's transference process, and at the same time encompasses the analytic formulation, which has formed a nodal point for the work since then, a point referred to in the analysis as the 'Rocket-suction' dream.

On the first day, a *Tuesday*, she was clearly happy and relieved to be back in analysis, spoke at length about the positive and negative aspects of the trip to her mother, then related a dream from Monday night. A man was presenting to a Customs official two white Israeli passports, each with a strange emblem on it. Her associations referred to the trouble in the Middle East. She had heard at home that her former boy friend was working in the Middle East, but had had to send his wife and children home. In conversation with her mother she had brought up her old grievances about the sabotaging of her love affair. She had had a sleepless night over it, but was pleased at how easily the bitterness towards her mother passed away.

I interpreted to her that the two white Israeli passports stood for the analytic mother's breasts, which the father part of the analyst was trusted to bring back safely to her from the dangerous outside world, a father whom the baby girl in her used to experience as the boy friend who would one day be her husband but was now acknowledged as mother's husband. The bitterness at the relinquishment of this hope was now better balanced by the restored sweetness of her relation to the mother and her breasts. I further linked the strange insignia with the nipple which was felt to be continuous with a penis inside the breast.

The following day she reported that to her surprise she had found herself walking down the alley in which she had met an exhibitionist some months previously. She believed she dreamed of having intercourse with her father or brother. At work she had a fantasy for the first time since the earliest months of analysis that it would be nice if her husband went away and she could have a love affair with the analyst. Her sister is believed to have a cancer of the breast, and she felt very hostilely scrutinized by this sister at times while at home, especially after she had made a comment on the patient's dark eyes. She herself made a silly comment one day to a sterile woman. Thinking to comfort the

woman about her sterility, she had said that her own trouble was that she could not keep from getting pregnant.

I interpreted that in her masturbation-phantasy dream she had again removed the penis, the 'strange' emblem on the Israeli passports, from the internal mother and attached it to the father's penis, with a resulting greedy desire to devour the penis on the one hand (the intercourse dream) and feelings of persecution on the other hand by this eaten-out mother and her breasts. She reported then in confirmation that that day she had phantasied an act of fellatio with a particular man she had known in her younger days. Seeing a picture of a baby resembling him had brought him to mind.

On the Thursday the material at first centred around a dream in which she discovered that her husband had been living with another woman for a year and was building for her a lovely cottage where only barren rocks had been before. The patient at first felt enraged and jealous, but this quickly passed, and she became concerned about the woman and whether her husband was being better to his new mate than he had been to herself. She associated to the cottage her parents had built when she was a baby and how they had taken her along, as she had heard, in her Karicot, in good weather.

This dream could be used to clarify for the patient the process of recovery from the consequences of Tuesday night's attack on the internal mother's breasts and consequent flight to a greedy attitude towards the penis in the paternal transference. Here she could see the acceptance of her baby position, on the couch as in the Karicot, admiring and appreciating the creative co-operation between the parents, fundamentally a reference to their coitus to which she had been a witness in the parental bedroom. The cottage in the dream, like the cottage of her childhood, represented the restored breasts and thus the restored character of the mother, receptive and comforting, as compared to the hard and barren rock-breasts of the depressed mother, the cancer-eaten, accusing-eyed mother-sister of yesterday's association.

She then spoke of her eczema being worse that day; that she did not trust the new nanny with the children; and then, at great length and with strong feeling, of how she disapproved of mixing penicillin and sulfa in the same syringe, that it was potent but dangerous.

When I interpreted that she was feeling the analyst now to be a restored mother injecting into the baby parts of her this dangerous analytic milk, a mixed product of penis and breasts, which gets under her skin, irritates her and might kill her, she replied that she felt afraid that the analysis would fail, that the analyst might be a 'split personality'. I interpreted that she had just split my head-breast again, separating the strength and creativity from the warmth and goodness, creating divided parents who were

unable to help her to restore the splitting in herself.

The Friday hour was spent largely in angry and frightened silence watching a storm outside, and on Monday she continued very resistant, but more sullen than angry. The analyst reviewed the material of the previous week. Towards the end of the hour she softened somewhat and revealed two dreams from the week-end. One was of a little boy's trousers in which the lining was worn out and torn. The other was of a girl's ski pants and two ski caps, one with the pom hanging down and the other with it standing up. Her associations were to her little boy's tantrums.

I reminded her here of the 'dangerous mixture' that I was felt to be injecting into her on Thursday and the explosive mood, reflected in the thunder-storm of the Friday hour with its angry silence. The dreams showed something in more detail, namely that the bringing together of these restored internal parents put her also into contact with her infantile bisexuality. But when we examine the little-boy and little-girl reactions to the week-end, we find the storminess only in the little-boy part with his trousers worn out from masturbation, while the little-girl part enjoys the warmth and protection of the twin breasts (the two caps) and her identification with the sexual mother (girl's ski pants).

On the Tuesday she was in a very loving and appreciative mood, sleepy and lazy. She had dreamed of a young mother carrying a baby. But towards the end of the hour she reported that her body felt like a stone, and she linked it with the druids, an 'ancient sect worshipping nature'—as she understood it—and then to Stonehenge and the plans for restoring some of the triglyphs by raising the fallen stones on to the columns. I interpreted both the appreciation for being picked up by me as a mother who understood the nature of babies and the threat to crush me if I throw her down again in order to go to the daddy, whose potency I was accused of worshipping.

This rather tenuous balance in the maternal transference persisted through part of Wednesday, but towards the end she became very persecuted, wishing to break off treatment, extremely concerned with her cancer fear, full of recriminations against her dead mother-in-law and anguish about her dead child. This reaction was not relieved by interpretation of content and its relation to the coming week-end. On the Thursday she did not appear until the very end of the hour. She reported that while on her way to the hour she had become so frightened by the idea that her children had stolen money from her purse, swallowed it, and were dying, that she had had to rush back home. She had then felt relieved, and wanted to call the analyst to explain but, being unable to find his telephone number, had come along to explain to relieve his worry. I was unable to spend any time with her nor did she press for any.

This coming to me constituted an extraordinary act of consideration on her part and the first acknowledgement that I must surely worry about her when she was late or did not appear.

The following day, Friday, produced this very rich nodal material: The patient was twenty minutes late, and talked at great length about the bad bus service and especially about buses not stopping for her. The analyst interpreted the continuation of her fear of my sucked-out breast-brain which she felt she had greedily destroyed and which she now feared would either desert her or offer her only a damaged and poisonous breast to suck linking it with the previous day's acting out. It was linked also with the sulfa-penicillin reaction of the previous Thursday and also with the events leading to the breaking off of her breast feeding of her little girl, especially her fear that one breast was watery and poisonous. She jumped up, rushed out of the room, and returned in two minutes explaining that she had had to urinate. The analyst said that his interpretation had brought her into contact with the feeling of having damaged the breast by sucking the penis out of it. This stolen penis was just then felt to be inside the baby part of her and now became a bad penis that urinated continually inside her and forced her to urinate, as we had seen earlier when the details of her urinary compulsion had been worked out.

The patient then related the following dream. She and her husband were on a motor scooter, she in front, but both had to tread on something to start it. It was a dangerous road and he fell off. She noticed that instead of a wound he had a tumour growing on his head with a white, fatty substance coming from it. She took him to the hospital for X-rays, but as soon as these were developed she snatched them and ran away, thinking now she would find out the truth for herself. She then found herself with a doctor and nurse inside a little cottage, a nursing home. He said, 'It is a myeloblast'. The patient reacted to this with grief and pity, as if her husband would have only a few days to live. A nurse said, 'The trouble is with the *rocket suction*', which the patient took as a reference to some trouble in the husband's urinary system or bowel. She then saw that the window was decorated for Christmas, and said to the doctor, 'What lovely weather; and only a year ago it was pouring with rain'.

Her associations went first to her own hypocrisy in the dream, recognizing that she was treating the creative myeloblast, which she knows very well to be the parent cell of the white blood cells, as if it were a cancer cell.

The analyst linked this for her with Thursday's acting out with her children in which she dramatized her identification with the analyst-mother accused of deserting the baby parts of her, leaving them to die from poisonous breasts of the internal mother (swallowing the stolen money). It was clear that the trouble was with the stealing 'rocket suction', not

with the good internal objects with which she was left. These were meant to comfort and sustain ('What lovely weather') and would so do, if not attached out of envy (wanting to find out the truth for herself).

By examining this dream in great detail, the whole panorama of greed and envy in relation to separation from the restored and harmoniously combined parents could be demonstrated as follows: At the outset the analysis is represented as something she and the analyst join in starting but which she steers. The analyst is kept in the sexual husband-father role. The week-end is at first asserted to be an accidental separation and a trauma to the analyst and his head. But this supposed trauma to him is suddenly acknowledged as beneficial to his analytic productivity (producing a white, fatty substance). In renewed envy towards this head which insists on being a breast, she snatches its innermost parts into her internal world (the X-rays she runs away with). But now even the internal breast (the cottage-hospital with the doctor-and-nurse staff) shows her the truth, that what she has stolen is a creative part of the breast (myeloblast) and that the trouble lies not with the intercourse (something wrong with the kidneys or bowel) but with her own envious greed (the rocket suction). Clearly this insight brings relief in the dream and a feeling of both greater confidence about the next holiday (Christmas) and a sense of accomplishment since the previous summer holiday, the destructive aspects of which had been represented most clearly in a dream of a burning dirigible with bodies raining down from it ('and only a year ago it was pouring with rain').

Review of Crucial Material

Let us now review the two weeks of analytic work. The patient had sought some refuge from her infantile separation anxieties in the transference during the summer break through a visit to her mother. She was pleased to find that she could bring out an old and virtually unmentioned grievance against her mother without lasting bitterness, but at the same time found that even this improved relation to her mother could not protect her from the infantile anxieties connected with her attachment in the transference to the analyst as both a mother and a father, i.e. linked to both internal parents.

The trust and expectation of renewed contact was reflected in the dream of the two Israeli passports, which filled the first hour with relief and pleasure. But the first night-separation brought an attack on these returned breasts, with renewed idealization of the father's penis as an object of oral greed, while the internal breasts became damaged and persecutory. Consequently her external relation to the analyst as a mother passed through a persecutory period which could be set right by interpretation. The satisfaction and gratitude for this restoration emerged clearly in the dream that night of 'the

cottage-where-barren-rocks-had-been'. In it there was manifest acceptance of her baby relationship to the two parents and acknowledgement of the reparative nature of the parental coitus.

Thus in three nights' dreaming and two days analytic work the first cycle of envious attacks on the internal mother's breasts and restoration of them by the good feed with the external mother was traversed in the transference.

But this was no sooner brought home to her, i.e. her dependence on the external analytic breasts, than the week-end loomed and the 'penicillin-sulfa-mixture' episode commenced. Despite reasonably prompt and correct interpretation, this persisted throughout the Friday session and on Monday also until near the session's end when she revealed bits of a dream. These helped to localize more satisfactorily the infantile rage coming from her little-boy (inverted) oedipal conflict, as seen in the dream of the 'worn-out lining'. This bit of clarification closed the second cycle of attack and restoration, bringing the 'mother and baby' dream and the happy Tuesday session, ending as it did with the 'Stonehenge' material and its implicit acknowledgement of being both a grateful and burdensome babe-in-arms.

This instability of the good internal and external relationship to the breast led inevitably to the third and most violent, but also most fully documented, cycle of attack and restoration. Before the Wednesday hour was ended, it had begun with the outbreak of depressive anguish and persecution intertwined, carrying through the acting-out with her children on the Thursday. The Friday session, with its 'rocket-suction' dream, made the termination of this third cycle possible with a degree of clarity and conviction for the patient that has made the dream a nodal point for the working through of this problem.

Aftermath in the Analysis—Periods 5 and Termination

At this point, I should like to restate the thesis of this paper, namely, that a particular form of stealing and denigrating attack, motivated by envious greed, undermines the stability of the internal relation to the breast and mother, forming a fundamental defect in those patients manifesting a cyclothymic type of disturbance.

I have up to this point demonstrated something of the revelation of this problem in the transference, its cyclical eruption under stress, and its restoration through the interpretive process. The working through continued during the following year, giving way gradually by the spring of 1959 to a new period in the analysis, characterized by the strong emergence of genitality, and related oedipal conflict, both direct and inverted. This development can be seen foreshadowed in the dreams of the 'little boy's trousers and the little girl's ski pants and caps'. As suggested there in the interpretive process, it was particularly the emergence with clarity of a vigorous

masculine genitality, all too delicately balanced constitutionally with her femininity in this particular patient, which took the centre of the stage during the following year of work, ushering in the termination phase.

I wish to make this point clearly, since it is central in understanding the whole metapsychological significance of this problem. Prior to working through this central difficulty, not only was the patient's primal good object *poorly established*, but the differentiation between maleness and femaleness both of her objects and of parts of herself was likewise on ever-shifting ground. With the new and increasingly firm differentiation of the creativity of the inside of the breast (and consequently of the mother and her character) from that of the penis (and therefore the father and his character) a more clearcut splitting and differentiation could take place between her own femaleness and maleness, starting in the depths with the infantile sexuality. This better splitting in the ego made integration possible, so that there could be a working through of the positive and inverted oedipal conflicts which had been a hopeless muddle in early life and in the first year of the analysis.

The aspects of clinical improvement that relate specifically to the working through of this central problem have been difficult to separate from the overall lowering of anxiety levels and improvement of reality sense. But I would agree with the patient who feels that the most striking, and to her unexpected, benefit has been the relief of the deep pessimism and yearning for death, linked as it was all through her childhood to the nagging feeling of 'not-belonging-in-the-family'.

Summary

The historical and psycho-analytic data from five and a half years of analytic work are presented to document the diagnosis and illustrate the psychopathology of a patient in order to demonstrate the metapsychological thesis of this paper. The patient, with a cyclothymic heritage in both parents, with a constitutionally intense and delicately balanced bisexuality, traumatized in the first three months of life by a painful, near-fatal illness, had dealt with the loss of the breast at weaning by a flight to the father which had a certain amount of reinforcement from the environment. This hypomanic state was based on the internal object relationships and defensive operations which are the central theme of this paper, that is, a denigration of the internal breast by an envious oral sadistic theft from it of a penis-like structure, felt as the core of its admired strength, creativity, and understanding, which was then projected onto the father's penis, thereby enhancing its admired

qualities to an exalted degree, making it the object of oral and genital greed.

This fragile elation collapsed at the birth of the next child and was intensified into depression by the subsequent family turmoil and separation, leading to a premature step forward in development in the form of a latency period, too hastily established and excessively rigid and joyless in its obsessional quality. Her subsequent history was encompassed in a repeated progression and regression between this hypomanic organization and the obsessional, the latter characterized by an improvement in her internal objects, brought about either by an internal process (a good coitus between the internal parents) or an external relationship (involving a transference to the good breast, such as her mother's rescuing her from suicide, or a good skiing holiday). But progress beyond this obsessional organization, with its omnipotent control over internal objects, acted out early in relation to the parents during father's drinking period and later acted out in her professional activities, was not possible. Continual oscillation between these two organizations resulted.

I have also tried to show how the pervasive pessimism about the value and purpose of life, as well as the deep feeling of unworthiness ('not-belonging-in-the-family') which nagged at her in childhood, were manifestations of the basic insecurity of her relationship to her good internal object and the related fundamental defect in her reality sense on all levels, good-bad, inside-outside, male-female (Freud, 1925).

Thus I have tried to demonstrate that the hypomanic organization, standing as it does as a first stage in regression from the obsessional organization and a jumping-off place for further regression into the manic-depressive psychosis or a more catastrophic fragmentation into schizophrenia, has as its good objects internally, not whole objects and not uninjured part-objects, but a damaged and denigrated breast and an idealized, exalted penis. The regression has taken place to a pathological state brought about by pathological mechanisms and not to a stage in normal ego-development. I have also shown that the tendency to regress to the hypomanic organization is due in great part to the un-integrated primal oral envy which tends to be set in motion by any internal or external stress. The analytic resolution of this tendency and preparation for development beyond an obsessional organization would therefore largely

depend on the successful reintegration of split-off oral envy toward the breast.

Discussion

There remains now only the task of reviewing briefly the history of the development of the psycho-analytic theory of obsessional and cyclothymic states and the transitional phenomena between them, in order to bring the contribution of this paper into historical context.

Abraham in 1911, opening cyclothymic states to psycho-analytic investigation and treatment, discovered the link between this illness and obsessions, particularly the role of ambivalence toward a love object in both. Freud, in 'Mourning and Melancholia' (1917), showed how the melancholic loses his object owing to regression to narcissism, while the obsessional keeps his love-object relationship. He revealed the alteration both in ego structure (due to the lodging of the abandoned object within the ego) and the altered distribution of cathexes (due to a heightening of the sadism of the ego-ideal towards the ego identified with the abandoned object). With great clarity and detail he described the nature of the 'ridiculing', 'denigrating', and even 'slaying' attacks by which the fixation of libidinal cathexis to this object, now in the ego, is loosened, both likening and contrasting this process with the work of mourning.

The fundamental formulation of mania was also offered, more tentatively, by Freud in this paper, namely the triumph over an object which had caused suffering and a limitation of freedom, through denigration of it and through the fusion of the ego with the ego-ideal. This was amplified in *Group Psychology* (1921).

The whole theory of manic-depressive states and their relation to obsessional states was brought into relation to metapsychology and to the stages in libidinal development in Abraham's 1924 paper, 'A Short Study of the Development of the Libido', where he added a clarification of how the object, by expulsion and reintjection after it has been denigrated and equated with faeces, becomes lodged within the melancholic's ego, stressing particularly the move from whole-object to part-object relations involved in the total regression from obsessional to cyclothymic organization.

This then was the foundation upon which subsequent developments have been based, developments in which the work of Klein plays

a unique role. By dissecting the superego in its deepest strata and tracing the multiplicity of internal objects found in the depths back to the earliest months and years of life, and by revealing the splitting processes within the ego in the depths and the complicated interrelationships among the internal objects and parts of the ego that underlie the general phenomenology of narcissism, she has laid the groundwork for a more detailed understanding of both these diseases we are discussing and the relation between them. In the chapter on Obsessional States in 'The Psycho-Analysis of Children' (1932) and in the 1934 paper on manic-depressive illness, she brought together Freud's and Abraham's conclusions, along with Helene Deutsch's discovery of the role of denial in mania, into a coherent theory. The relationship to the breast of the internal mother was shown to be the foundation for the vicissitudes of mood, a conclusion with which Edith Jacobson, in her 1957 paper, seems in fundamental agreement, allowing for her special way of expressing things in terms of self- and object-representation. Klein added to Deutsch's findings about denial her own stress on the *denial of psychic reality* as central in the manic defences against both the depressive and paranoid anxieties which result from sadistic attacks in the good internal objects, especially the breast.

During the years after 1934, while Klein's findings were being integrated around her construct of paranoid-schizoid and depressive positions in ego development, other workers interested in the area of mania were struggling with the phenomena of hypomania. Angel, Deutsch, Lewin and Fenichel seem all to have recognized the ubiquity of the problem itself, and

the nature of many of its separate basic elements such as the role of oral greed and sadism in relation to the breast, the role of denial, of erotization, of identification with the primal scene, of idealization of the penis, of the part-object nature of the relationships. The thesis of this paper integrates these various elements by relating them to the oral sadism toward the inside of the breast and body of the mother (*The Psycho-Analysis of Children*, 1932).

In 1957, in *Envy and Gratitude*, Klein brought forward evidence of the central role of unintegrated (and thus unmodified) oral envy in undermining the security of the relationship to the good internal objects, primarily the breast. In the light of this discovery, it is necessary to re-evaluate her own and other workers' contributions to the metapsychology of obsessional and cyclothymic states and the transitional processes between them.

To a great extent this paper attempts to do this in the small area of the phenomenon of hypomania, both as an acute reaction and a characterological structure. I have shown (i) the nature of the internal object relationships in hypomania, stressing (ii) the central role of unintegrated oral envy towards the breast in producing the regression from the obsessional organization, differentiating this factor from (iii) the more protean stresses, internal and external, which may release the envious attacks. I have also indicated and illustrated (iv) the internal and external processes by which the obsessional organization can be recovered, emphasizing that (v) only by a process of integrating the oral envy can the way be cleared for progress beyond an obsessional state into the fully differentiated positive and inverted genital Oedipus complex.

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THE ROLE OF GRIEF IN PSYCHO-ANALYSIS

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The purpose of this paper is to re-emphasize the importance of psycho-analysis as a process, placing special emphasis on the importance of the grief work and the peculiar characteristics which differentiate it from all previous experience. The grief-work which occurs in the unique environs of the psycho-analytic situation and 'seals' the cure will be referred to as effective grief, since it seems to me to differ from the daily recurring grief work described by Freud (1917).

It is my hypothesis that the child cannot grieve effectively, and therefore cannot relinquish the earliest essential object-relationships. This means that the repetition compulsion must continue in full command of the personality until the time when the ego discovers that it can tolerate the postponed separation anxiety and, so strengthened, can face the work of grieving. This mastery of original grief is essentially different from the working through of ordinary day-to-day grief, as described by Freud and others.

With experience, first as a patient and increasingly as a therapist, I have been intrigued with the role that grief and effective grief-work play in recovery during treatment. It has become clearer, as I hope the elaboration which follows will show, that one of the most important goals during the psycho-analytic process is the patient's attainment of the ability to grieve effectively, since it is my feeling that without a prolonged period of effective grief there can be little permanent change or lasting personality reorganization. Since I am talking not only of sadness, mourning, or the reaction to present loss which reawakens reaction to past loss, but of a unique emotional response experienced, perhaps, only in the psycho-analytic process, I have chosen, for the time being, the term 'effective grief' to describe and differentiate it. The patient reaches a point in therapy when the particular response is available to him after a great deal has been made conscious and after

the ego, strengthened by the acceptance of the therapist, has developed the courage to discard its infantile behaviour patterns.

Simple grief-work does not require a special ego state; it results in the transfer of libido from one object to another with the same concomitant intensities and distortions. Effective grief-work takes place only after the ego has undergone certain strengthening experiences; it results in a deintensification of the original object-relationships and of all of the operations of the id.

At one point in my psycho-analytic training it occurred to me that my colleagues and teachers must be keeping a closely guarded trade secret, a secret that they neither discussed, wrote about, nor taught. I went so far as to imagine that since, to me, the subject of the secret was the essence of the psycho-analytic process, it was guarded to prevent its becoming a subject for intellectualization, so that it could be discovered by the analysand in all its intensity in order to ensure recovery. This did not turn out to be the case: there was no such secret; there was, however, a very neglected aspect of the psycho-analytic process. This neglect is still very puzzling, for it seems to be the crux of the matter.

What is this matter with which we are concerned in our daily work? Is it not a process, employing a certain scientific method, which has as its goal the freeing of the patient from his repetition compulsion? Is not the degree of illness the extent to which he distorts his present living in terms of his past experience? Is not neurosis the degree to which the present is misconceived, distorted, and reacted to, as influenced by the phenomena of transference and of the repetition compulsion? This degree varies from distortion and misconception that negate the present to relative freedom from the distorting influence, not of the past itself, but of those factors in the past which give rise to the need to repeat earlier behaviour patterns. The patient;

comes to the analyst to get rid of something. As Nunberg (1949) states, 'By health, the patient means something different from what the physician does, namely the gratification of all kinds of desire, impulses, expectations, hopes and so on. . . . Thus the wish for recovery contains, in the unconscious, two contrasting roots, one that emanated from the ego and hopes to gain control over the instincts, and the other coming from the id, which hopes for gratification of the instincts.'

Fairbairn (1941) uses different words when he describes treatment as 'resolving itself into a struggle on the part of the patient to press-gang his relationship with the analyst into the closed system of the inner world through the agency of transference, and a determination on the part of the analyst to effect a breach in this closed system and to provide conditions under which, in the setting of the therapeutic relationship, the patient may be induced to accept the open system of outer reality'. It is only when such a struggle ensues in all its intensity that growth in the therapeutic situation can take place. And so the troublesome symptoms and ways of behaving that cause difficulty in living inevitably plague the patient as he listens to his thoughts while relating them to the doctor. As the patient talks, he begins to repeat in thought and feeling all the patterns of behaviour he has ever used in relating to the significant persons of his past and present, until all his neurosis, that is, his infantile demands and his particular ways of seeking satisfaction of them—his own unique repetition compulsion—seems now confined to the person of the analyst.

Isaacs (1948) notes that 'the patient's relation to the analyst is almost entirely one of unconscious phantasy, and it is the making conscious of this phantasy that much of the treatment is concerned with, for in doing so it is found that the analyst not only has come to symbolize the most superficial and most recent objects but, also, as these displacements and sublimations are understood, the most primitive objects as well.' When the phantasy is made conscious and the patient can see the distorted and irrational elements in his thinking, is he cured? Of course not. He knows a great deal more about himself, but he is powerless to stop his repetitious behaviour. In fact, it is often at this point that he becomes more intent than ever upon satisfying his neurotic demands. What then is required of him? To answer this we must look again at the possible source of power that uncon-

sciously propels him in his irrational, repetitious behaviour patterns.

Silverberg (1948) succinctly states that it is fundamentally human not to admit that there is something that one wants but cannot have, and explains the repetition compulsion and its component, transference, on the basis of such a feeling. It seems to be the universal experience that one makes a '... persistent attempt to deny the presence of those frustrating and restricting forces which have compelled the transition from the state of infantile omnipotence to the sense of reality, and makes a persistent attempt to undo that transition and to traverse it in a reverse direction. In all of its variety and multiplicity of manifestation, in all the attitudes and behaviour which are its expression, transference may be regarded as the enduring monument of man's profound rebellion against reality and his stubborn persistence in the ways of immaturity.' Ferenczi (1913) formulated the hypothesis that infants begin existence in a state of subjectivity, without distinguishing between self and the world external to it, and this produces a state of omnipotence which is modified with difficulty, through disappointments and failures in achievement and through education into a more objective appraisal of the world and the individual's relation to it. Balint (1952) further elaborates the omnipotent position by stating that satisfaction of all need is crucially important because of the infant's absolute dependence on the object. He then lists three conditions necessary for the existence of omnipotence: (i) certain objects and satisfactions can be taken for granted; (ii) no regard or consideration need be paid to the object; and (iii) there is a feeling of extreme dependence; i.e. the object and the satisfaction by it are all-important. Survival depends upon maintaining control over the object, then, and the continuous feeling of omnipotence will be continuous reassurance that the object is still controlled, and survival thus guaranteed.

The separation which the infant fears as meaning death, and which when imagined or imminent gives rise to anxiety, is as inevitable as physical growth; and in an effort to avoid anxiety caused by change from the known to the unknown, the infantile object-relationship is perpetuated through unconscious displacement. The phantasy is that nothing has changed from the time when he possessed those objects that represented satisfaction, security, and survival: as long as the illusion of omnipotence is so perpetuated he will never have to face the reality

of the separation that is so threatening. He would seek those objects whose symbolic representation reminds him of his infantile feeling of security and omnipotence, and would treat them in such a way as to maintain the illusion of his power which, paradoxically, was greatest when he was most helpless and most passive. Later in life, when the 'separation' or 'separateness' has lost all its destructive possibilities, he continues the phantasy which, for the rest of his life, will exert its neurotic influence through the unconscious.

It would be impossible to discuss the role of grief and grief-work, both simple and effective, in the psycho-analytic process without quoting liberally from Freud's concise and thoughtful description in 'Mourning and Melancholia' (1917). 'Mourning is regularly the reaction to the loss of a loved person, or to the loss of some abstraction which has taken the place of one, such as one's country, liberty, an ideal and so on. . . . In what, now, does the work which mourning performs consist? . . . Reality testing has shown that the loved object no longer exists, and it proceeds to demand that all libido shall be withdrawn from its attachments to that object. This demand arouses understandable opposition. . . . This opposition can be so intense that a turning away from reality takes place, and a clinging to the object through the medium of a hallucinatory wishful psychosis. Normally, respect for reality gains the day. Nevertheless its orders cannot be obeyed at once. They are carried out bit by bit, at great expense of time and cathectic energy, and in the meantime the existence of the lost object is psychically prolonged. Each single one of the memories and expectations in which the libido is bound to the object is brought up and hypercathected, and detachment of the libido is accomplished in respect of it. Why this compromise by which the command of reality is carried out piecemeal should be so extraordinarily painful is not at all easy to explain in terms of economics. It is remarkable that this painful unpleasure is taken as a matter of course by us. The fact is, however, that when the work of mourning is completed the ego becomes free and uninhibited again.'

In the psycho-analytic process, the patient is encouraged, both by the method and by the 'attitude' of the therapist, to relive his psychological development and, as the past is relived, to discover that he can experience the separation anxiety that so much effort and energy have gone into avoiding, and to grieve effectively. May we

not consider the entire psycho-analytic process, from the long and tedious recall to the final burst of grief which, at last, accepts the loss of the phantasy of the infantile object-relationship, as a mourning one?

Melanie Klein (1952) describes what seems to her necessary for ego change before the repetition compulsion can be altered: 'I suggested . . . that one of the factors which bring about the repetition compulsion is the pressure exerted by the earliest anxiety situations. When persecutory and depressive anxiety and guilt diminish, there is less urge to repeat fundamental experiences over and over again and, therefore, early patterns and modes of feeling are maintained with *less tenacity*. These fundamental changes come about through the consistent analysis of the transference: they are bound up with a deep-reaching revision of the earliest object-relationships and are reflected in the patient's current life as well as in the altered attitudes toward the analyst.'

Helene Deutsch (1937) notes that whenever grief in the adult takes an abnormal course, the severity of the abnormality is due to the intensities of ambivalence toward the lost object and that the abnormal course may appear as melancholia, anxiety, absence of grief, and suicide. She concurs in the hypothesis that 'the ego of the child is not sufficiently developed to bear the strain of the work of mourning and that it therefore utilizes some mechanism of narcissistic self-protection to circumvent the process . . . the fate of the omitted grief is the question of chief interest for us in the analytic history. . . . If grief should threaten the integrity of the ego, or, in other words, if the ego should be too weak to undertake the elaborate function of mourning, two courses are possible: first, that of infantile regression expressed as anxiety, and, second, the mobilization of defense forces intended to protect the ego from anxiety and other psychic dangers. The most extreme expression of this defense mechanism is the omission of affect. It is of great interest that observers of children note that the ego is rent asunder in those children who do not employ the usual defenses, and who mourn as an adult does. . . .

'The process of mourning as reaction to the real loss of a loved person *must be carried to completion*. As long as the early libidinal or aggressive attachments persist, the painful affect continues to flourish, and, vice versa, the attachments are unresolved as long as the affective process of mourning has not been accomplished'

(and is still a part of the repetition compulsion).

'Whatever the motive for the exclusion of the affect—its unendurability because of the ego's weakness, as in children, its submission to other claims on the ego, especially through narcissistic cathexis . . . or its absence because of a previously existing conflict with the lost object; whatever the form of its expression—in clearly pathological or in disguised form, displaced, transformed, hysteriform, obsessional, or schizoid—in each instance, the quantity of the painful reaction intended for the neglected direct mourning must be mastered.

'In any case the expediency of the flight from the suffering of grief is but a temporary gain, because, as we have seen, the necessity to mourn persists in the psychic apparatus.' *As long as this grief is not mastered, the repetition compulsion is in full command, forcing one to act as if the object had not been lost.*

As the ego grows under the acceptance of the therapist and its particular repetition compulsion is made conscious through the analysis of the transference, it reaches a point where for the first time it can tolerate the anxiety and grief against which it has been forced to defend itself. The experience of tolerating anxiety further strengthens the ego, so that at last it can make its compromise with reality and grieve away the infantile object-relationships.

Mourning, as Freud describes it, is for everyone a daily experience on some level of consciousness. The result of grief-work meant to him, I gather, withdrawal of the libido from this object and transference of it to that new one. Such a transfer is not in itself effective in bringing about a change in the personality. Effective grief-work results not only in giving up the object, but in a deintensification of the drive which determined the person's neurotic attachment to the object. The libido is not just transferred, but the inherent quality of the attachment is changed. In fact, it may not be transferred at all but only deintensified, as with incorporated objects where the nature of the attachment is altered rather than severed. The object is contained within the mourner without the previous neurotically determined attachment to it. That is, the incorporated object is seen more realistically and retained in a new relationship with the mourner, the object now devoid, or more nearly so, of wish-fulfilling distortion. This distortion may diminish *ad infinitum* as the grief process continues.

Lindemann (1944) describes the symptoma-

tology and management of acute grief, noting that 'it is a definite syndrome with psychological and somatic symptomatology, that may appear immediately after a crisis; it may be delayed; it may be exaggerated or apparently absent. In place of the typical syndrome there may appear distorted pictures, each of which represents some special aspect of the grief syndrome and, by appropriate techniques, these distorted pictures can be successfully transformed into a normal grief reaction with resolution.' He notes that there is a tendency to avoid the syndrome at any cost, to refuse visits lest they should precipitate the reaction, and to keep deliberately from thought all references to the deceased. Anxiety and physical exhaustion—indicative of efforts at repression—guilt, hostility and morbid identification, seem to be pathognomonic of loss. He notes that 'patients with a history of former depressions and with obsessive personality make-up are likely to develop an agitated depression', rather than a normal grief reaction.

Abram Blau (1955) mentions depression as a way of attempting to maintain the phantasy of possession, just as Searles' (1956) provocative paper on 'The Psychodynamics of Vengefulness' gives us data about the flight from grief and describes another defence, that of vengefulness, which serves psychologically to hold on to the object as if it had not been given up. Depression, too, can be an effort to avoid grief by holding on to the object.

'Melancholia,' said Freud, 'is in some way related to an object-loss which is withdrawn from consciousness, in contradistinction to mourning, in which there is nothing about the loss that is unconscious.' So often the lost object is perceived by the depressed person and grieved for but without relief, for what is not perceived is the symbolic importance of the object.

Mrs A., a 44-year-old wife and mother, was severely depressed because she felt that her life was empty without the love of a physician who had been particularly helpful to her. She surveyed, under pressure, the realistic factors in the situation and saw that divorce and remarriage were impossible, even if it should transpire that he returned her feeling, of which she had grave doubts. The 'little girl' quality of her attachment with idealization of the object in order to increase her feelings of security became clearer. Her depression did not lift until she began to see how she had cast the doctor in the idealized role of her father, who had died suddenly when she was five, and with whom she still had imaginary reassuring conversations.

Mr B., a 50-year-old lawyer, became enamoured of a secretary who had worked in his office for many years, feeling that he could not live without her. The fact that she did not love him pained him but did not decrease the intensity of his longing for her. Again, his depression did not decrease until he began to see her as a symbol of all his infantile desires which had been repressed, and to realize that it was her motherly quality which had attracted him.

In neither case was it clear what had precipitated the sudden reliving of the phantasy with a real person cast as the idealized object, but each had been subject to increasing frustration and hurt from a spouse.

Mr C. sought help for his severe anxiety when he found that his wife was dying of a malignancy. His capacity for grieving was great, and, though grief-stricken, he was not depressed. It became clear to both of us that, whenever he thought of separation from his wife, he found himself remembering his childhood and times of separation from his mother, and that his present grief contained elements of grief about earlier separations. Not all the factors involved in his readiness to grieve have become clear, but it does seem that the conscious connexions between the present and past objects made his grief effective and played a part in preventing his being depressed.

Freud says of melancholia, 'So we find the key to the clinical picture; we perceive that the self-reproaches are reproaches against a loved object which have been shifted away from it on to the patient's own ego.' Mrs A. and Mr B., in the examples cited, divided their reproaches between the guilty self and their respective mates with a resulting dichotomy of the good and bad external objects. As long as this position was maintained there was no chance of giving up either object. Mr C., on the other hand, was aware of his disappointment in his wife and of his guilt-tinged anger and so was freer to grieve through the separation.

The courage to perceive what has been lost, its symbolic significance, and the ability to examine one's ambivalence about the object become prerequisites for effective grief-work. Melanie Klein (1940) felt that the child went through states of mind comparable to the mourning of the adult and that this early mourning was revived whenever grief was experienced later in life. To return to the example of Mr C., it would appear that it is indeed true that early periods of mourning, or rather, periods of hurt when he did not consciously mourn or effectively grieve, were revived by his wife's illness and death, and revived

because he, as a child, had not been able to solve them 'by carrying out the behest imposed by the testing of reality', and that only now, in his adult life, could he meet the requirements necessary for accepting reality, both in the past and in the present. She also stated that in the depressed position of infancy '... the object which is being mourned is the mother's breast and all that the breast and the milk have come to stand for in the infant's mind: namely, love, goodness, and security.' Neurosis is inevitable; the form it takes is determined by many factors. 'In normal development,' she says, 'these feelings are overcome by various methods.' Again, it is her view that when, in the infant, the depressed position is reached, the ego is forced to develop methods of defence which are directed against the pining for the loved object. These defences are against admitting that the object and its symbolism of love, security, and power are lost.

Mr E., who sought treatment during separation from his wife prior to her getting a divorce, felt that he could not live without her and prayed to God and to me to get her back for him. His mood during this early period was depressed and he was persistently manipulative. 'She was mine,' he said, 'why couldn't I do anything I wanted to her? She is my life.' He was unaware of the neurotic quality of his possessive control of her, which seemed quite natural to him, and was really perplexed that she did not return his 'deep love'. He had repeated with her the all-or-nothing relationship he phantasied he still had with his mother. He exhibited, in his four hundredth hour, the essence of his infantile omnipotence, meeting all Balint's requirements, and made a last ditch stand in the transference to perpetuate his omnipotence with me. His depression was a defence against grief, a refusal to mourn, and a reluctance to feel the hostility which would lead to the experience of loss.

Freud states that the occasions giving rise to melancholia for the most part extend beyond the clear case of a loss by death, and include all those situations of being wounded, hurt, neglected, out of favour, or disappointed which can reinforce an already existing ambivalence. Effective grief work during psycho-analysis arises from the loss of a phantasy which included protection against all those hurtful experiences. In my experience, anxiety is the forerunner of effective grief, as if a period of anxiety toughens the ego so that it can let go of infantile objects. Klein feels that destructive impulses are the primary factor in the causation of anxiety since

the infant feels that whenever the mother disappears she has been destroyed by his sadistic impulses. He is afraid not only that she will not return to satisfy his needs, but that some feeling in himself is responsible for her not returning. Not having his needs met is cause for anxiety, as is the feeling in himself which might bring this about.

Anger is the admission of the loss of the fiction of one's omnipotence, since inherent in anger is the realization that one is not getting what one wants. The repression of certain kinds of anger also serves to maintain the omnipotent position.

We may ask why the infant on weaning cannot give up the breast and its symbolic representation. The child is not psychologically equipped to grieve effectively, for reasons already mentioned, nor for that matter is the adult, until certain emotional experiences have strengthened the ego. This orientation leads one to the conclusion that there is no grief experience to compare with the effectiveness of the psycho-analytic one in freeing the individual from the neurotic attachments of childhood. If, by the time there is the potential to grieve effectively, the incorporated objects are unknown and the primary external objects displaced, where else but in psycho-analysis can these be made conscious? And where can the emotional charge of all the investments in unattainable goals and objects be invested in one person, a person who could tolerate the inevitable separation following such an attachment?

It would seem that, at least to be effective in deintensifying the infantile demands, grief-work accomplishes the giving up of the symbolic representation of the objects embellished by all the wish-fulfilling characteristics given them to avoid the pain of reality. The child wants some-

thing, cannot have it, is frustrated, becomes angry, feels anxiety, and cries, giving it up and choosing another object, but always with the same persistence and intensity, so that the problem and tension are moved into another area. Effective grief-work must result in a lessening of the persistence and of the wanting, so that reality factors, such as availability, desirability, and symbolic significance of the object, are taken into account. Only if this happens can the repetition compulsion and its manifestation in transference be interrupted. This is the last and most fateful stage of the process, upon the intensity of which depends the outcome of all of the work that has been done before, and without which little has been effected in the interest of permanent growth.

These ideas, born of psycho-analytic experience, postulate that all neuroses develop because the infant cannot grieve effectively, but must build systems of defence against the acceptance of reality, i.e. the necessity for giving up object-relationships. Neurosis then becomes the inevitable direction of growth that can be changed only by effective grieving as the final stage in the psycho-analytic process.

Freud writes of grief as passing off after a certain time without traces of gross change. Is it not that change takes place only when effective grief-work has occurred? It is only during true grieving that the defences of a lifetime are relaxed, and whenever thereafter grief is inhibited or repressed, all defences, although less intensely, return, and symptoms recur. This suggests that grief-work never accomplishes its goal completely, but, once made available, may continue throughout life, bringing increasing freedom from infantile neurotic goals as it increases recognition of reality and the most appropriate responses to it.

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DENIAL AND MOURNING

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In 'Mourning and Melancholia', Freud (1917B) suggested that we could gain insight into the nature of melancholia by studying the 'normal affect of mourning'. As had happened before in psycho-analysis, the study of pathological phenomena shed new light in turn on our understanding of a facet of normal psychology. In this paper I shall attempt to employ this same methodology which has been so fruitful as well as valid in the past.

Mourning is the reaction to the loss of a loved one. It is a painful process which manifests itself in feelings of grief, loss of interest in the outside world, and loss of the capacity to love. The loss of object precipitates a struggle within the psyche between the reality recognition of permanent loss on the one hand, and the disinclination to abandon a libido position on the other. Withdrawal of libido takes place bit by bit, requiring a good deal of time and energy (Freud, 1917B).

Freud considered melancholia also a reaction to loss, either real or imagined. He pointed out that the response to loss in this condition was one of introjection with all its consequences. By linking mourning and melancholia and exploring them simultaneously he could discern that the nature of one's reaction to the loss of a loved object depends upon the prior relation to that object, that the elements of narcissistic object choice and ambivalence were especially significant in determining a more normal or more pathological outcome.

Abraham (1924), who considered melancholia an archaic form of mourning, observed that 'in the normal process of mourning, too, the person reacts to a real object loss by effecting a temporary introjection of the loved person.' In discussing the relation of identification to object loss in *The Ego and the Id* Freud (1923) states, 'It may be that this identification is the sole condition under which the id can give up its objects.' These observations of Freud and Abraham have since been confirmed so fre-

quently and so consistently that Fenichel has summarized the essence of the mourning process as consisting of two acts: 'the first being the establishment of an introjection, the second the loosening of the binding to the introjected object' (1945, p. 394).

The concept that introjection is the universal response to object loss helps us to understand a wide variety of pathological grief reactions as well as many of the transient symptomatic disturbances that accompany normal mourning. We are impressed by the fact that the normal manifestations of grief, as well as such reactions as recurrent nightmares, hysterical tics, paranoid reactions, and hallucinatory psychoses, reflect the inner struggle of the ego both to escape and to master the pain of loss. Freud (1926) suggested that this pain is due to the same psychoeconomic conditions as are produced by physical pain, namely, the cumulative effect of a continuing stimulus that cannot be escaped. In the case of object loss this stimulus is the mounting cathexis of the longed-for object.

Freud (1916) also mentioned a tendency to avoid the mourning process itself. He refers (1917A) to cases in which the individual denies the loss and substitutes his own wishful fantasies for the painful reality. This attempted repudiation of the loss differs from all other forms of mourning in that it tends to bypass the whole problem of the vicissitudes of the introject. The implications of this tendency on the part of the mourning ego are best discussed in conjunction with clinical illustrations.

(1) An elderly woman was rushed to the hospital by her family following the sudden onset of a stroke. Within a few hours she died, and the attending interne immediately informed the several grown children who had remained at the hospital. Their immediate reaction was disbelief, and together they went in to see their mother. After several minutes they came from her room insisting that she was not dead, and they requested that the family physician be called. Only after the diagnosis was confirmed by a

second physician did they accept the obvious reality and give vent to their intense feelings of grief.

(2) A 23-year-old woman broke into violent sobbing as she told me that her mother had died two years earlier. She recalled that at the funeral she felt numb and experienced no emotion whatsoever. Her relatives admired her composure, and she herself was defiantly proud that she did not break down. She said, moreover, that her mother's death had never seemed real. Whenever she drives the hundred miles to visit her family she anticipates a pleasant day with her mother, and on each occasion she experiences intense disappointment upon discovering that her mother is not there.

The first case is a clear example of a temporary denial that is quickly abandoned in the face of reality. The second case, however, demonstrates the kind of compromise Freud described in his paper 'Fetishism' (1927), namely, a splitting of the ego with one part refusing to acknowledge the reality, death, and the other being fully aware of it. He states, in an apparent reference to the 'Rat Man', 'The patient oscillated in every situation in life between two assumptions: the one, that his father was still alive and was hindering his activities; the other, opposite one, that he was entitled to regard himself as his father's successor.'¹

Perhaps it is stating the obvious, but before one can establish the introject the loss has to be acknowledged. In cases of total denial this process may be postponed for years (Fleming and Altschul, 1959). Denial accompanied by simultaneous acknowledgement is the more common occurrence.

(3) A 19-year-old girl was interviewed five years after her mother's death. She mentioned that at the funeral she had felt that the woman in the coffin did not look like her mother. Frequently when she climbed the stairs at home she feared that she would meet her mother, and she really was not completely convinced that this had not on occasion happened. Even after five years she still entered her mother's bedroom with the expectation of finding her there.

The failure to complete mourning, accompanied by the feeling that the departed still lives, is actually quite common. In summarizing a number of articles that describe the various reactions of mourners, Bowlby (1960) reports, 'All accounts dwell on the insistence with which behavior, thought, and feeling tend to remain oriented toward the lost person. Despite the

knowledge that he will not return, there is a continuing sense that nonetheless he is present.'

It is my hypothesis that these cases of denial and ego splitting are not just a special type of reaction to loss, but have a direct relation to normal mourning, just as does melancholia. I would regard them as interruptions of mourning which permit us to observe particular stages in what is usually a fluid process, somewhat like stopping a moving picture at a particular frame.

(4) A young college girl reacted to her mother's death with depression, weight gain, and partial immobilization. Direct expressions of grief through tears and recollections were absent, and she did not connect her depression with her mother's death. After the funeral she continued to maintain her mother's bedroom as before. She would take dresses from the closet and iron them as if they were to be worn. She would discuss her current problems with her mother's photograph and feel sad that her mother didn't answer. This behaviour had been going on for three months at the time she sought consultation.

After several weeks her therapist pointed out to her that she was continuing to act as if her mother still lived. Her immediate response to this was a flood of tears, followed by recollections of her mother's appearance at the time of death. A period of active mourning with affective expression, numerous reminiscences, and typical dreams followed. This was accompanied by a lifting of the depression and a resumption of her normal activities. Only then could she collect her mother's life insurance and order a headstone.

While this case clearly demonstrates the splitting of the ego, one is impressed by the fact that there has been a retardation rather than an arrest of the mourning process. The depression and weight gain suggest that some degree of introjection had taken place. Yet the girl's behaviour reflected a persisting tendency to consider her mother as an external living person. The therapist's activity served to reinforce her reality testing, or at least to improve communications between the two parts of the ego.

In some cases of object loss the process of mourning is completely arrested at some intermediate stage and the entire reaction repressed. Subsequent reactivation during analysis provides a special opportunity to observe how mourning is completed by a strengthened ego.

(5) A 26-year-old single woman entered analysis because of recurrent episodes of depression. During

what I can't understand is why it doesn't come home to supper.

¹ In *The Interpretation of Dreams* (1900) Freud reported the following reaction of a 10-year-old boy to his father's sudden death: 'I know father's dead, but

the anamnesis she mentioned without particular emotion that her father, a coal-miner, had been killed in a cave-in when she was 9 years old. The initial phase of analysis was not unusual, as she gradually developed a clear father transference. When the first tentative transference interpretations were suggested, however, she reacted with violent denial. She asserted that the only time she was really affectionate with her father was when she was 2½; otherwise their relationship had been distant and unimportant.

Her associations during the ensuing weeks of analysis became progressively centred on her father and the many things they did together. Something about the way she spoke of him as well as a dream involving Easter suggested to me that we were dealing with a fantasy of her father's resurrection or return that was as yet unclear. Although my ideas about this were still vague, I mentioned them to her. She became very upset, protested, and pointed out as evidence of the unlikelihood of this idea that she had never grieved for her father. Her recollection of her reaction was that she had felt she must take over for father and comfort her mother and younger sisters. She also recalled a weight gain of thirty pounds following his death.

This defensive protest, in itself revealing, did not last long, and she was able to recover many additional memories of which the following is a condensation:

She recalled being among the crowds that had assembled at the mine during the rescue operations. She was convinced that her father was safe, but, as time passed and hopes dimmed, she created a fantasied escape tunnel from which her father would emerge. After the funeral, which she attended, she continued to expect her father's return. She created new explanations of where he had gone and why his return was delayed. Many times she played out in her fantasies the dramatic scene of his sudden reappearance. Gradually these productions occupied less of her conscious fantasy life and apparently were repressed.

The elaboration of these fantasies in the analysis culminated in a sudden recollection during an analytic hour of the director of the rescue operations saying to her 'Little girl, your father is dead.' Upon remembering this she was overwhelmed with grief.

Shortly after beginning analysis this woman developed periodic attacks of facial swelling that were diagnosed as angioneurotic oedema. The evening following the analytic session just discussed she suffered another attack and, while reporting this to me, she recalled her father's appearance in the coffin, namely the bloated face and expanded chest. When I suggested the obvious identification with her dead father she mentioned that her facial swelling was accompanied by a tight, painful feeling in her chest. There has been no recurrence of the angioneurotic oedema during the succeeding three years.

In retrospect it appears that the reactivation of mourning began with the analysis; at least the repeated attacks of facial swelling suggest this. The effect of repression was to preserve in the unconscious the fantasies of denial. With the lifting of repression these fantasies could be re-evaluated and corrected by the strengthened adult ego, and thus permit the completion of mourning. The analytic situation provided an opportunity to examine in detail the relationship between denial and mourning.

As a prelude to discussing this relationship I would like to quote the following from *An Outline of Psychoanalysis* (1940):

'We must return to our statement that the infantile ego, under the domination of the external world, disposes of undesirable instinctual demands by means of what are called repressions. We can now supplement this by a further assertion that, during the same period of life, the ego often enough finds itself in the position of warding off some claim from the external world which it feels as painful, and that this is effected by denying the perceptions that bring to knowledge such a demand on the part of reality. Denials of this kind often occur, and not only with fetishists; and whenever we are in a position to study them, they turn out to be half-measures, incomplete attempts at detachment from reality. The rejection is always supplemented by an acceptance; two contrary and independent attitudes always arise, and this produces the fact of a split in the ego.'

Freud (1915), Moellenhoff (1939), Sterba (1948), and Wahl (1958), among others, have pointed out that denial of the reality of death is a general attitude in our culture. It is easily enough observed in mourners. We treat the dead in our thoughts and actions as if they were alive. We try to make them look alive by the use of cosmetics; we speak quietly in their presence so as not to disturb them; we say good-bye to them, sometimes even with a kiss; we consider their feelings in choosing an attractive and comfortable coffin; and finally, after they are buried, we create an afterworld in which they continue to live, and we even arrange occasional return visits for them in ghostly form. Yet despite this active denial we know that they are dead and we weep for them.

The loss of a loved one is potentially a traumatic situation. The ego is faced with a painful reality that it is helpless to alter. Acknowledgement of this reality threatens to flood the ego with the totality of libidinal and aggressive cathexes formerly invested in the object. Mourning is the ego's method of retard-

ing the flood by loosening the attachment in small quantities. 'What today is called grief is obviously a postponed and apportioned neutralization of a wild and self-destructive kind of affect which can still be observed in a child's panic upon the disappearance of his mother or in the uninhibited mourning reactions of primitives' (Fenichel, 1945, p. 162).

It is my conclusion, then, that the initial reaction to the loss of a loved one is denial accompanied by a splitting of the ego. This splitting of the ego is a reflection of the actual psychic state of affairs in that the ego is faced on the one hand with a highly cathected mental representation of the loved object, and on the other with an absence of perceptions of the object. The splitting is a compromise that acknowledges both realities.

We can picture what follows the splitting somewhat schematically. The instincts, still attached to the object representative, strive for gratification and repeatedly force the ego into the position of seeking the object and finding it

absent. With each observation of this absence that part of the ego which has yet to acknowledge the loss experiences a degree of pain and reacts to the recognition of loss by the regressive process of introjection. Although the ultimate fate of the object representative may be total incorporation, normally this is the result of a series of partial introjections. We know this from observing the coexistence of denial and introjection as well as the transitory partial identifications that accompany normal mourning. Concurrent with this series of partial introjections is a parallel series of partial detachments from the introject. This is suggested by the gradual diminution of sadness and the slow renewal of energy that take place during mourning.

Introjection is an attempt to preserve the object, but it is also a step toward giving it up. In fact it does not take place until the loss is acknowledged. Denial is also an attempt to preserve the object, but perhaps its more basic function is to preserve the ego.

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BOOK REVIEWS

The Psychoanalytic Situation. By Leo Stone. Freud Anniversary Series. (New York: Int. Univ. Press, 1961. Pp. 160. \$3.30.)

Leo Stone's 1961 Freud Anniversary Lecture at the New York Psychoanalytic Institute is devoted to the psycho-analytic situation. While an excellent, though necessarily compressed, exposition of the subject, it is dominated above all by an urgent, almost impassioned plea for recognition of the human element, which he regards as apt to be lost in the technique of practising analysis. At the basis of this estrangement, he feels, are the two roles of scientist and therapist, which the analyst must somehow combine. Freud commended the surgeon as a model for the integrative task.

The analytic situation, with its rigidly codified behaviour for both patient and physician—its laws of abstinence for the one and its mirror injunctions for the other—disposes towards an elimination of many of the modes of behaviour and points of contact between people which are most characteristically human. A circumscribed verbal contiguity alone is permissible; the physical and emotional relationship of both partners is one of 'deprivation-in-intimacy'. Two isolated minds, imprisoned in machines, transmit their vital need for each other exclusively through the medium of words which may constitute at times a frail instrument for communication of the tensions of life.

Some message of humanity must nevertheless be conveyed, according to Stone, if therapy is to result. The inclination to mutual withdrawal is otherwise too strongly entrenched in the procedure to overcome the separation and rejection problems that are at the roots of neuroses. The burden of responsibility is on the analyst; he must recognize and somehow persuade the patient that the scientific aspects of the analytic situation are in the service of the therapeutic and that the analyst is at all times a physician—interested, sympathetic, and dedicated to the welfare of the analysand; (the narrower problem of the medical versus the lay analyst as healer does not enter into this discussion, as Stone makes clear).

In a review of the origins and functions of the rule of abstinence, the mirror ideal, the couch technique with its sensory and motor deprivations—all contributors to the mechanizing aspects of analytic technique—he finds the formulations ambiguous and not infrequently taken out of context. Repeatedly they are mingled with admonitions which exhort 'nevertheless' to common sense, tact, and exceptions

in their use. Stone would reverse the procedure and have the special admonitions and the exceptions made into a rule that would entail 'a subtle shift in the general base line of the classical psychoanalytic situation'; the therapeutic intent should be operative and perceptible at all times.

Some, no doubt, will question the picture of the cold mechanical analyst that is thus unveiled for scrutiny, and will ask if this scientific automaton is an exception or perhaps just an abstract guide; is the scientist taken to task unjustly for dedication to an ideal that is justified by the results? The 'mechanical analyst' has long been a stock figure brought on the stage for caricature by opponents of analysis whose criticisms were flagrantly instigated by hostility to or lack of understanding for analytic goals and procedures. The 'overscientific analyst' is twin to the 'unscientific' one who is alternately invoked by the critics; the polar errors of refraction tend to be cancelled when the diverse images are superimposed upon each other.

Dr Stone's views come not from the outside but from within the citadels of classical psycho-analysis, and must be regarded as a self-corrective tendency in the tradition of an ever evolving and changing procedure. He invites and even requires debate on attitudes and techniques that have been left all too frequently in the shadowy area of tacit assumptions, intuitions, and private constructions which are not satisfying either as science or as therapy—particularly if, as Stone indicates, they have actually bred a race of mechanical monsters. Psycho-analysis follows its own inherent dispositions in hyper-cathecting such areas with attention and thought.

The disposition to ponder the degree of 'friendliness' and therapeutic zeal in the analysis has in fact a long history. Stone mentions ideas of friendliness on the part of the analyst that entered the scene 'larvally' and 'cautiously' in 1950, but Freud had already spoken in 1937 of the positive transference which it was 'our business to wake' ('Analysis Terminable and Interminable') and in the same paper referred to patients who had to be perpetually treated like children. There were countless references of a similar nature in still earlier analytic literature. It is scarcely revolutionary when Stone pleads with the analyst to accept responsibilities, such as to insist on a needed medical consultation; in 'An Outline of Psychoanalysis', Freud placed therapeutic obligations in the foreground (not for the first time) with the comment that 'the analytic physician and the

weakened ego of the patient base themselves upon the *real external world* ' (my italics).

Similarly, the issues raised by Stone might have seemed more cogent if he had accorded greater recognition to the potential resistances behind the human aspects of the patient's demands and the analyst's responses. Perhaps these were considered too obvious and familiar to require mention; nevertheless, it comes as somewhat of a surprise to the experienced clinician to find that questions as to the analyst's intended vacation resort are 'innocuous' and that to withhold the desired information may be unnecessarily frustrating and establish a status barrier. Surely such questions may be innocuous but they are not innocent, and it is the special interest of the analyst in their true meaning rather than inhumanity which leads him to remain silent only to establish a more genuine and satisfying communication with the patient when the underlying question ultimately emerges. Variations are indeed possible and at times to be recommended, but one wonders about the general principles involved when Stone feels impelled to deal with incorrect fantasies about himself by giving the analysand authentic facts. This too may have its indications, but matters might be placed in context if it were more clearly indicated that confrontations and interpretations are useful techniques in dealing with such problems.

The discussions of techniques and their humanity or lack of it thus tend to become dissociated from the fundamental goals of the analytic procedure and their results. If it appears that a patient insists on investing the analyst with priestly authority, it may represent an artefact arising from the procedure; but is not analysis inherently self-corrective in holding up the awe of the analysand itself for scrutiny and tracing its origin and effects either in the immediate or the remote situation, as the case may be? If the patient and the analyst find themselves repeatedly silent and baffled by lack of understanding as to what is going on, it is indeed the responsibility of the analyst, as Stone asserts, to intervene; but is the needed intervention a demonstration of his friendly though baffled intentions? The most typical core of resistance in analysis is still the demand of the patient for sexual satisfaction—one that is scarcely testimony to the mechanical impression created by the analyst.

In his discussions of the analytic situation, Stone is inclined to stress the external framework but to overlook the actual dynamic motivator. It is the analytic pact which is the essence of the analytic situation, not the couch or the mirror technique, which are auxiliary measures subject to modification. Through the pact, the analyst becomes an 'ally', in the light of reality a 'helper' and 'adviser' to the sick ego ('An Outline of Psycho-Analysis'). The rejection by the patient himself of this medical role constitutes the point of departure for the entire

analytic procedure. The analytic pact, amply and explicitly described on numerous occasions, guarantees the very therapeutic bond for which Stone appeals; the 'cadaver model' which he seems to regard as more typical should be viewed as a distortion and not a part of the genuine pact which seeks to cure, not to dissect the patient. Nor is science in medicine limited to autopsies; it becomes disturbing when Stone at times seems to feel that meticulous attention to the scientific aspects of analytic technique smacks of the machine and is inherently incompatible with common sense and kindness. Is the baseline that he proposes, a blend of science and humanity, insensibly being replaced by the idea that the two are not to be blended after all?

A correct understanding of the analytic pact 'based on reality' would, one might suppose, take into account the healthy ego and need not involve the analyst in a conflict between science and humanity, as Stone suggests, when the patient is impelled to go to the bathroom. The trends in the author's thinking become even more pronounced when he recommends that the 'strains' of the classical situation for both participants be relieved in the terminal phase by introducing a psychotherapeutic regime with infrequent sessions, face-to-face confrontations, and a resolution (evasion?) of the transference neurosis by opportunities for analyst and analysand 'really' to get to know each other. The rationale here could readily be applied to earlier stages of treatment and might even make unnecessary or impossible the growth of the transference neurosis, which can be so disturbing to the humanitarian outlook.

Yet though we may differ with the manner in which Stone develops his thesis, there is no escape from the conclusion that there are paradoxes and misunderstandings implicit in the task of combining scientific and therapeutic attitudes. This occurs, of course, not only in analysis but in other fields of medicine, especially where modifications of the patient-physician relationship have been brought out by specialization, extensive laboratory procedures and group practices of different types. Nor can we feel confident that the problem of the mechanical analyst does not exist (like Stone, we do not speak here of the anxiously defensive beginner). Personality factors are sometimes responsible, as are traditional or individual constructions that tend to ritualize the analytic rules or place a premium on passivity for the analyst (the counter-cadaver model?).

What is often needed is not a release from science but a greater knowledge of it. As early as 1910, Freud commented that changes in the analyst's conception of his task had introduced a *friendlier* note into the treatment; ('The Future of Psycho-Analytic Therapy'). Estrangement between patient and analyst may be the outcome of a mistaken belief that the verbal aspects of the analytic relationship

preclude attention to and interpretation of important non-verbal modes of adjustment and communication during treatment. The world outside the analyst's consulting room is always part of the analytic situation. A one-sided concentration on the infantile roots of behaviour to the exclusion of their current and autonomously flourishing derivatives may devitalize the proceedings that are thus so artificially constricted. The necessary corrective is not a demonstration of the analyst's good will or of his real personality, both of which may obscure or complicate the actual difficulties, but rather a reconsideration of theory.

Not that we need deny that humanity is an indispensable component of the analytic treatment; psycho-analysis is a science of human relationships that cannot possibly exclude it. At times in the past—and it is doubtless not extinct in the present—there has been a disposition to breed mechanical analysts. The latter may in fact be considered endogenous faults within the analytic process, internal dangers with a certain degree of ego-syntonicity in contrast to the obvious deviationists on the outside. Leo Stone's lecture thus offers a welcome and compelling invitation to a self-directed character analysis of the classical procedure.

Mark Kanzer

Anorexia Nervosa. By Helmut Thomä. (Bern and Stuttgart: Huber and Klett, 1961. Pp. 352. DM 18.50.)

Dr Thomä's book is more than a monograph on *Anorexia Nervosa* written from a psycho-analytic point of view. Almost one half of its 332 pages (plus 20 pages of bibliography) consists of two quite extensive psycho-analytic case histories which are of value to psycho-analysts whether or not they are specifically interested in *anorexia nervosa*. The author discusses critically and in considerable detail questions of nosological classification, constitutional factors, pathogenesis, various psychological approaches to the theory and treatment of this condition, differential diagnosis, somatic symptomatology, somatic therapies. He gives a succinct and thoughtful survey of the history of the *anorexia nervosa* syndrome, beginning with Morton's description of two cases in 1689, to the classical descriptions of Gull in England and Lasègue in France (1873) and to the confusion with Simmonds' disease (pituitary insufficiency) earlier in this century. Nowadays the syndrome is clearly differentiated from an endocrinological disorder, its psychogenic nature, recognized by Gull and Lasègue, is re-established, although in much more sophisticated form than was possible in the days of Gull and Lasègue.

Anorexia nervosa, while not a disease-entity—however ill-defined—like schizophrenia or hysteria, is considered by Thomä as a syndrome with fairly

well-marked clinical characteristics. This is in contrast to a recent American monograph on the same subject (Bliss and Branch, *Anorexia Nervosa*, New York (Hoeber), 1960) where a weight loss of twenty-five pounds or more, attributable to psychological causes, is considered, for purposes of their study, as the sole diagnostic criterion. According to Thomä, the following characteristics distinguish *anorexia nervosa* from other conditions leading to malnutrition and emaciation: (1) preferred age puberty and post-pubertal period; (2) preponderance in females; (3) psychogenic restriction of food intake; (4) spontaneous and induced vomiting, frequently carried out in secret; (5) amenorrhea appearing before or concomitant with weight loss, more rarely after onset of weight loss; (6) constipation; (7) somatic sequelae of malnutrition, in severe cases leading to death. This combination may make its appearance as a more or less well-circumscribed syndrome, and may best be described as the presenting symptom complex in a variety of character disorders, hysterical, obsessive-compulsive, depressive, or schizoid, or as the prominent expression of an adolescent crisis of pathological proportions. There are, then, psychopathological characteristics in themselves not specific for this syndrome, dysfunctions not directly related to malnutrition (amenorrhea, vomiting, constipation), and somatic sequelae of psychologically determined starvation. In a number of cases, despite even a high degree of marasmus, the patients show amazing energy and motor activity.

The study is based on the examination and treatment of thirty *anorexia nervosa* patients, seen over a period of ten years (1950 to 1959) in the department of psychosomatic medicine of the University of Heidelberg Medical School. Five cases were clinically cured (average duration of illness three and a half years). By clinical cure is meant a more or less complete cessation of symptoms. The author points out that this does not necessarily mean a cure of the underlying psychological disorder, since follow-up studies could not be thorough enough to arrive at a reliable judgement on such a complex question. Five cases were much improved after an average of two years of illness. The rest were either only moderately or slightly improved (nine), were unchanged, got worse, or could not be followed. Of these thirty cases nineteen underwent psychotherapeutic treatment, duration of treatment varying from thirty months to two weeks. Of these nineteen patients, the improvement in eight cases was definitely attributable to psychotherapy, nine improved more or less spontaneously, in two cases no improvement occurred. Patients were seen three to five times weekly. Psychotherapy of all cases was psycho-analytically oriented, and, as mentioned earlier, the two extensively reported cases can be considered as psycho-analytic case studies, the analyses extending over periods of two and two and a half years.

respectively. Three cases are reported less extensively. Twenty-five case reports in briefer form are not included in the book but are available, the author states, to interested colleagues upon request.

While Thomä does not claim impressive successes for the psychotherapeutic treatment of anorexia nervosa, he feels that in the long run patients who undergo psychotherapy have a more favourable prognosis. Of the thirty cases included in the study, nine refused psychotherapy. The author stresses the strong narcissistic element in anorexia nervosa patients which makes many of them not easily accessible to long-term therapy; they tend to reject the physician, as Freud stated for the narcissistic neuroses, not so much because of hostility, but out of indifference. The symptoms, although frequently severe from the viewpoint of the objective observer, are, in a sense, ego-syntonic, indeed consciously fostered by the ego's drive-restricting and drive-denying tendencies. The author frequently refers to Anna Freud's description and discussion of adolescent asceticism, an asceticism which involves both 'hunger and love', both sexual and aggressive drives. Eating and sexual activity are easily equated, and both have prominent sexual and destructive connotations for these patients, leading to drive inhibition and drive denial. Surrender to bodily needs and instinctual demands is abhorred. This tends to engulf, along phobic lines, many of the patients' activities and needs, especially human relationships. The establishment of a workable doctor-patient rapport and the development of a transference-neurosis is thus fraught with difficulties. In the more severe cases, any sign of clinical improvement, or of a positive transference, runs counter to the patients' defensive needs and efforts and increases guilt and need for punishment, so that the conditions for and the danger of a negative therapeutic reaction are constantly present, tending to provoke well-known countertransference reactions.

If Thomä's claims for the therapeutic success of psycho-analytically oriented treatment and of psycho-analysis in anorexia nervosa cases are modest, he extols the value, especially of psycho-analysis proper, as a research tool for arriving at a true psychodynamic understanding of the syndrome. Its psychogenic nature being established, such understanding is of the utmost importance for developing an optimal treatment technique. The question of the importance of the family environment as an etiological factor in the development of the syndrome remains open, since the detailed investigation of this factor would require special methods and prolonged studies of family interaction. On the basis of his experiences the author comes to the conclusion that there is no evidence for a constitutional disturbance, either in the morphological sense or in the sense of hypothalamic or endocrine dysfunction. The role of early feeding and eating problems remains undetermined. In

three of the five case histories such difficulties are mentioned by the mothers.

The two extensive case reports, and an additional shorter but still somewhat detailed report, give a wealth of most instructive material in regard not only to biographical details, but especially also in regard to the treatment process, transference manifestations, the handling of the transference, dreams, resistance and defences, countertransference problems and, last but not least, in regard to favourable ego changes (case of Henriette A.). I shall give brief summaries and dynamic formulations of two cases, closely following the author's own summaries and formulations. Henriette A., a 19-year-old college student when she started treatment, had become ill at age 16, following the development of an erythrophobia. She blushed when boys in school looked at her or erotic themes were discussed, and she found that she could deal with this difficulty if she fasted in the morning. Fasting became more extensive, and as she started to lose weight the embarrassing tendency to blushing disappeared. The psychodynamic constellation is described as follows: her blushing was an expression of her embarrassment about being a girl. She clearly wanted to be a boy. Her father died when she was one year old; mother never remarried, and the patient remained an only child. From early on Henriette assumed a masculine role in relation to her mother, substituting in many ways for and identifying with the dead father. An intense, long-lasting friendship with a girl her age was characterized by Henriette's dominance and later by homosexual activities. In her conflict over her sexual identity, coming out into the open in puberty, she tended more and more towards an ideal of asexuality. An uncompromising opposition of drives and ego became established, leading to the ascetic, asexual ideal-formation. Denial and avoidance of external danger situations and drive repression reduced conscious anxiety. Hunger became the conscious representative of instinctual drives and the conquest of this need became the goal. Drive repression led to restriction of ego functions, manifested in inhibited personal relationships, in work inhibition and difficulties in concentration, and to somatic symptomatology (vomiting, constipation, amenorrhea). In the anorexia we can see her avoidance of drive-satisfaction, her retreat from the drive-object, with gratification in phantasy through daydreams concerned with food and eating. Anorexia as well as her amazon-like general attitude and behaviour represented her rejection of receptivity ('Nothing shall be let in'). Nourishment and impregnation were equated. Disgust and vomiting were expressions of her rejection of sexuality as well as of aggressive-destructive impulses since oral gratification represented both to her. Her conscious guilt feelings were focused on eating and eating phantasies. Personal relationships carried the double danger of sexual and aggressive involvement, so that

the patient became more and more lonely. Her fear of the omnipotence of thought and wishes suggested an intense longing for such an identity of phantasy and reality and for a union where all opposites were resolved and abolished. Such omnipotent needs were also manifested in her ideal of asexuality and self-sufficiency. In the course of the analysis blushing and erythrophobia reappeared (after some sixty hours of treatment), a first sign that the ascetic-aexual pseudo-solution of her conflicts had been disturbed. The pathological development could be reversed and more useful solutions of the reactivated conflict, centring around sexual identity, were initiated. Clinically, the patient, by the time the analysis was terminated, had markedly improved, somatically, psychosexually, as well as in regard to her work inhibition, so that she had been able to come to a successful conclusion of her undergraduate education by the time treatment ended. Weight was close to normal, eating habits and constipation were improved, and the menstrual cycle was normal again. It is not possible to do justice here to the rich analytic material and to the insights into the analytic process afforded by the original case report.

While Henriette A.'s illness can perhaps best be characterized as a prolonged adolescent crisis, the second patient, Sabine B., presents a very different picture. She came to treatment at age 26, anorexia nervosa having started at 21. She was the third of five siblings in a family of low social-economic status. While there had been eating difficulties in childhood, anorexia developed following diphtheria and post-diphtheric polyneuritis followed by psychogenic dysbasia. The diphtheria, originally diagnosed as tonsillitis, developed after a date with a young man who tried to kiss the patient who rejected his advances. The whole sequence of events is most interesting and suggestive in its psychosomatic implications. Sabine had suffered from a number of compulsion symptoms prior to her acute illness, and these subsequently became aggravated. In addition, more severe hysterical, depressive, and paranoid symptomatology became established. While her relationship to her mother, partly in connexion with pronounced sibling rivalry, was disturbed from early on, there existed an intense and obviously pathogenic relationship with her paternal grandmother for many years. It seems that the ego-ideal of an asexual, good, clean, beautiful doll-child grew under the influence of the grandmother. On the basis of intense oral ambivalence, established in early childhood, strong reaction-formations of disgust concerning food, bodily functions, body-contact, human relationships in general, developed. There was fear of being poisoned by food unless it was specially prepared by her mother. During the five years of illness preceding treatment she spent most of the time in bed in a darkened room, cared for by her mother and one of the younger sisters. She dominated and punished her family by her excessive passive demands, no

overt aggression being available to her. With few and brief interruptions, the patient had spent the years prior to the outbreak of anorexia nervosa, as a retiring but passively demanding girl, restricted in her interests and activities despite good intelligence. The beloved grandmother had died when the patient was 12, and this event, to which Sabine reacted with periods of depression, initiated her more pronounced ego-restriction. Menarche, at 15, was greeted with loathing and disgust. Needless to say, oral and anal impregnation phantasies were predominant. Attraction to a young man in her twenty-first year led to increased denial of sexual differences and to a defensive regression to an oral level; in the words of the patient: 'I wanted to be as little as a baby, time stood still'.

I cannot begin to give an account of the course of the analysis (304 hours). This must be read in the original. Dream material was abundant and used extensively. Dreams, as well as the colouring and style of the analysis, had much in common, if I am not mistaken, with child-analysis, which is not surprising considering the primitive, underdeveloped character of this patient. It is obvious that she communicated much more by way of picture-language, closer to primary process, than by thought language. The tendency was to couch interpretations given to the patient in such language also, and to give resistance interpretations more freely than content interpretations. I would question whether the author is correct in his retrospective assumption that these tendencies on his part made a resolution of her conflicts on a higher psychic level difficult and are responsible for the fact that there was definite improvement of her social adjustment only, without much evidence of dynamic changes. Any more profound changes of her primitive character structure could probably have come about only as a result of a much more prolonged analysis. What apparently was achieved was a loosening-up and favourable modification of her superego whose archaic nature was most impressive. Follow-up inquiries four years after termination of treatment revealed that the patient has been able to work as an aide in a private hospital, leaning on nurses and doctors, still a timid, compulsive, odd girl, underweight and amenorrhea persisting.

The last chapter of the book, entitled 'Psycho-genesis and Psychosomatics of Anorexia Nervosa', is devoted to very thoughtful, critical considerations of such issues as etiological factors, the problem of regression in its significance for the development, course, and treatment of the syndrome; ambivalence, object relations, and identification in their bearing on the character structures and symptom formation of these patients, as well as of more specific psychosomatic topics. The last part of the chapter deals critically with a number of different psychopathological and psychotherapeutic approaches such as the so-called neoanalytic theory of neurosis (Schultz-

Hencke) and existential analysis. The author's point of view is decidedly psycho-analytic, based on Freud's theory of neurosis, metapsychology and ego-psychology and their more recent developments; he is thoroughly familiar with the pertinent British and American literature.

Distinguishing between neurosis following some traumatic experience, and neurosis as the manifestation of some failure or inhibition of the developmental process (Freud), Thomä concludes that, typically, the latter is the case in anorexia nervosa. Actually, this distinction is not one pertaining to etiology, but to the mode of development of the illness. The anorexia nervosa patient, in most cases, becomes ill in consequence of her failure to cope adaptively with the conflicts of psycho-sexual maturation and development arising in adolescence. These conflicts in a very specific way are related to the somatic growth processes of puberty, so that the intertwining of psychological and somatic symptomatology is here perhaps less surprising than in other conditions. We do not deal here with conversion symptoms. Amenorrhea, for instance, is compared to amenorrhea in situations of acute or chronic stress (prison, concentration camps) and the author tends to see the amenorrhea in anorexia nervosa patients as a physiological reaction to a situation of inner stress rather than as an expression of 'rejection of femininity'. Vomiting usually is not predominantly the expression of unconscious disgust, but the expression of unconscious disgust, but the physiological reaction to conscious rejection of food, and is often consciously provoked. Nevertheless, it seems difficult to establish mutually exclusive alternative explanations for these psychosomatic phenomena. Thomä—as becomes clear in his discussion of psychosomatic problems and theory (especially on pp. 131–135)—is fully aware of the complexity of the clinical and conceptual issues involved, and avoids many of the fallacies encountered in psychosomatic writings. He discusses the vomiting of anorexia nervosa patients, as well as their constipation, within the framework of their negativism and their ego-attitudes of defiance, stubbornness, and passive aggressivity (although he does not use this last term).

His comments and discussions on psycho-analytic theory, as it pertains to his topic, are clear and informative. They do not offer anything new to the psycho-analyst, but are obviously addressed more specifically to the psychiatric and medical reader. In discussing existential analysis, Thomä makes a significant contribution to the critique of this theory and treatment method. In writing for a German-speaking public, this today is an important focus of attention, popular as existential analysis appears to be in Germany and Switzerland. Moreover, the influence of this approach has spread to the United States, in the wake of American interest in existentialism in its various forms as a philosophical move-

ment. The author has more than a passing acquaintance not only with different exponents of existential analysis such as Binswanger, Boss, and others, but also with the philosophy of Martin Heidegger, who, at least as far as these authors are concerned, can be called the father, albeit perhaps unwillingly, of their theories. My own early familiarity with Heidegger's philosophical work, dating back to the twenties, and my passing acquaintance with Binswanger's and Boss's contributions, make me appreciate this critique. It may be summarized in Thomä's statement that psychotherapy, in the form of existential analysis, becomes the handmaiden of a philosophical system. Existential psychopathology and psychotherapy consume themselves, as Thomä puts it, in the effort to serve two masters—the patient and the structure of his symptoms on the one hand, and the philosopher and the structure of his existential categories on the other. One certainly cannot avoid the impression that both Binswanger and Boss, with different degrees of scientific and philosophical naïveté, attempt to transpose insights and concepts of Heidegger's philosophy directly into psychopathology and psychotherapy, as though scientific theories and therapeutic approaches could simply be deduced or translated from a new philosophical system. An elucidation of psycho-analytic theory in terms of Heidegger's philosophy, if this be a worthwhile endeavour, would require indeed a great deal of theoretical and philosophical sophistication and work. To throw psycho-analytic theory out the window, as Boss advocates (he does not advocate it for psycho-analytic practice and technique), because it is not conceived within the framework of existential philosophy, would be as scientifically naïve as throwing out modern theoretical physics because concepts of time and space are used or implicit which are not in concordance with Heidegger's new formulations concerning temporality and spatiality, however illuminating and fruitful these may be.

A succinct summary of the monograph is given on pp. 330–332, and there is an extensive bibliography. Dr Thomä's book is well written, in a fluent and lively style not frequently encountered in German scientific literature.

Hans W. Loewald

Leonardo da Vinci. Psycho-Analytic Notes on the Enigma. By Kurt R. Eissler. (New York: Int. Univ. Press, 1961; London: Int. Psycho-Anal. Lib. and Hogarth, 1962. Pp. 375 + plates. \$12.50; 65s.)

The book reviewer has a twofold obligation. To the author he must convey his grasp of the book's essential intentions; to the reader, on the other hand, he has to pass on as vividly as possible what he thinks the reader should know before he reads, and to facilitate acquaintance with the book's main ideas in case there is no intention of reading it. Criticism and fault-finding are the easiest of tasks but always lack some intrinsic justice. This is especially the case

with regard to an experimental treatise on the possibility of reconstructing psycho-analytical data of a great man's life. Eissler himself wants us to understand that he carries out the experiment of understanding a great, almost legendary figure of the past by using none but psycho-analytic tools. He applies them on a wide foundation. Beginning with polemics, he goes on to historical notes, to methodology, to problems of object relations and to notes on Leonardo's artistic creativity, ending (apart from four appendices) with a very interesting essay on the meaning of Leonardo's Deluge paintings and an even more important theory on trauma.

The composition of the book is rich but has the inevitable drawback that the richness of argumentation and psycho-analytical deduction will win the book as many enemies as friends. The first argument which will be used against Eissler's method might be that Leonardo was a man of the Renaissance and that we have the minds of Modern Man. But was not Leonardo to his century as much a modern man, a scientist of a new order, as Freud has been to his? Our century studies mental structure and aberrations in exactly the same revolutionary way and with exactly the same hazards that Leonardo's age found in the study of body structure and dynamics.

There is not here the question of right or wrong in a biographical sense. All must remain supposition, but the book is soundly based on clinical observations which have been collected in our own scientific era about the structure and dynamics of man's destiny. This is what we expect from a modern biography.

A German poet of the post-classical period once suggested that every man of letters should write his own *Faust* during his lifetime, and many were written during four centuries. Eissler must have felt the same about Leonardo. He knows that the interest in this universal genius is waxing and his book is sure to contain an important contribution on the enigma, Leonardo. Leonardo's childhood history, or what we know of it, occupies comparatively little space in the book. Eissler pays more attention to problems of maturity, conflict, and matters of identity finding.

The chapters on homosexuality seem to be rather overloaded compared, for instance, with the most fascinating issues of the artist's depressive and creative phases, to which an analyst of the English school would probably pay more attention than Eissler has done. One would, however, not like to miss a beautiful sentence like the one from Chapter 12, page 150, which forms the bridge between the syndrome of homosexuality and depression:

'From clinical observation one knows the type of personality isolated by iron barriers from the world and suffering deeply because of his prison-like existence. The manifest homosexual relationship is then the only access there is to the world. Sexual pleasure is in such circumstances of moderate or little importance and by no means

the primary motive. It is rather the temporary relief of a deep grief that holds such a man like a prisoner in restraint, that compels him to indulge sporadically in sexual relations with a mirror image of his past existence; it is the only access to the world that is kept free.'

The 'indescribable and incorporeal' sadness which permeates all Leonardo's compositions reveals also their meaning. They are not 'well preserved', either as object relationships or as the products of his artistic fantasy life. 'Indescribable' sadness is a feature of every artist's, every child's, and every lover's history.

We remember here a cultural factor which the book does not stress. In Renaissance times children were suckled up to the age of 2 or 3. Never do we see the portrait of an infant-in-arms lying at the Virgin's breast. Furthermore, children of the upper classes were never suckled by their own mothers, but were sent to the country for the first few years to be breast-fed by sturdy peasant women. Leonardo was 'privileged' to be suckled by his own Caterina. This explains his removal to his father's house from the age of 4 or 5 as a much more conventional move than has hitherto been stressed. Shame and guilt at having been suckled ('seduced') by his own mother are likely causes of his sexual inhibitions.

As regards Eissler's reconstruction of the fateful year when Leonardo left for Milan, I should like to make a personal contribution, based on many years of intensive study of the subject. In 1478, the year of the famous Pazzi conspiracy, one of Leonardo's most important patrons, Giuliano dei Medici, was murdered. This seems the keypoint of Leonardo's decision to leave Florence. Only in Milan did Leonardo become the great artist we know today. Eissler regards this phase as Leonardo's 'breakdown of structure' and development of new qualities. We might add that Leonardo identified with the murderer to the extent of living through a traumatic experience of the first order. Before he left Florence, we hear of his drawing of the murderer, Bernardo Blandini, who had fled to the East but had been sent back at the request of Lorenzo dei Medici and hanged at the end of 1479. Eissler takes the drawing of the 'hanging man' to be the effect of trauma.

The dramatic moment when at the Last Supper Christ says, 'But, behold, the hand of him that betrayeth me is with me on the table,' is shown by Eissler to have been chosen by Leonardo for its immensely traumatic character. No painting before Leonardo's ever exhibited this moment of tension. This is, to our way of thinking, an ingenious interpretation. It confirms many hypotheses stipulated by analysts as to the problems of guilt, depression, and so-called projective identification (a highly controversial and obscure name for an important process where temporary loss of identity is involved). Eissler describes the impact of trauma as having contributed to Leonardo's greatest work. How accurate his reconstruction is at this point can be

proved by a 'coincidence'. Lorenzo dei Medici put under the effigy of his brother Giuliano's murderer the threatening sentence:

'A new Judas was he who must expect a death more cruel.'

Not very long after this, when Leonardo is already 'safe' in Milan, he starts on the 'Last Supper' and long and wearisome becomes his search for living models for Judas's and Christ's heads. What wealth of insight into Leonardo's identity struggles this fact affords us!

'... As soon as Christ had announced the presence of the traitor, not only did the group temporarily dissolve and panic threaten as a result of the sudden freeing of libidinal cathexes (see Freud, 1921) that were invested in the ties to the other group members and Christ, their leader, but they were suddenly confronted with the task of searching their own souls. Thus a situation of the greatest security was changed from one moment to the next into one of the greatest insecurity, the individual member facing a task for which he was utterly unprepared and not equipped to deal with.'

Eissler thinks of Leonardo as someone easily traumatized, on the brink of dread most of the time. This may hold good for every artist and for every artist's childhood history. I think Eissler's argumentation in this direction is of utmost importance. Frightening pictures or impressions threaten to break through the barrier against stimuli in every young and dependent creature. Only a few have the gift of introjecting and reprojecting those pictures and impressions instead of entirely repressing them. This would be the essential synthesizing aspect of those activities by which creative artists are distinguished from other people. The artist would then be that privileged being who experiences reality more fully and earlier, and refuses to accept it more dynamically than more adaptable people. Klein said something rather similar in her paper on 'Infant Analysis' (1923). The passages on Leonardo would have been eminently suitable for quotation in this book. Eissler draws our attention to the awe and admiration in which artists are usually held, which, by the way, contrasts sharply with the lack of consideration which they usually encounter. In our modern way of thinking we would see the reason for this contrast as lying in the envy of his contemporaries which so often spoils the admiration that an artist deserves.

Analysis proves daily that any fact of the artist's life will necessarily become the vehicle for his imagination. No one says that a fact of life can become the source of inspiration for creativity, yet analysts are constantly reproached for saying this. Eissler rightly fights this prejudice in his chapter on polemics.

He argues that the creative artist is one who can never rest until he has reprojected (repaired, remodelled, reproduced) the traumatic even in a creative act which equally repairs the

artist's ego. We understand thus the dynamic effect which Leonardo's 'Last Supper' or his 'Mona Lisa' produces in every beholder. We have long understood the autobiographical value and pungency of Goethe's *Werther* (which led to a succession of suicides in Germany). The ego, in danger of fragmentation through trauma, integrates in the act of creativity, the victim turning aggressor in a sublime sense. With this stipulation about trauma, Eissler refutes successfully those critics who would have nothing to do with the influence of actual experience on an artist's choice of subject.

The book ends with a construct on Leonardo's drawings of deluge. The sterile periods of Leonardo's life, as documented in his 'Armenian letters', have, in my view, not received quite sufficient consideration. These letters are the one entirely non-artistic output which has come down to us from all Leonardo's work. It is those faked letters from the East (whither Giuliano's murderer fled) which give the most emphatic answer to the dynamics which have accumulated in Leonardo's last artistic interest and work: the numerous drawings of 'The Deluge'. Eissler calls them the artistic expression of Leonardo's premonition of his own death, and 'Weltuntergang' feelings.

The selection of reproductions of Leonardo's scientific and artistic lifework has been carefully and tastefully made. These pictures speak the strongest language where words fail us.

One can doubt whether contemporary general readers will wish to have those questions answered which Eissler tries to answer. What may happen is that a much younger generation will find no objection to the book; where we arouse prejudice, we simultaneously create the world in which these prejudices will no longer exist, and new concepts of truth may create new styles of beauty.

Eva M. Rosenfeld

Psychiatry. Vol. 1. By E. Eduardo Krapf. (New York and London: Grune & Stratton, 1961. Pp. 244. \$6.50.)

The author of this book, the first volume of what promises to be one of the most unconventional and interesting textbooks of psychiatry, belongs to an uncommon species of psychiatrist which is now becoming extinct. Their basic training included becoming extinct. Their basic training included neurology and clinical psychiatry as well as psychoanalysis. As Chief of the Mental Health Section of the World Health Organization, Professor Krapf has an unrivalled knowledge of current trends in psychiatry. To write a textbook must be try all over the world. To write a textbook must be much more difficult for a man with his long and varied experience than for a representative of a particular school, however important. The author's orientation is not only multi-dimensional but also cosmopolitan. This is almost unique in psychiatry, where adherence to a school of thought is usually

combined with a national bias. Professor Krapf withdrew from academical teaching some time ago. This book is therefore unlikely to have been written for a particular body of students, as are most textbooks; it may be assumed to be addressed to students of psychiatry of all nations and age groups. The author is an individualist and eclecticist of unusual catholicity. He considers himself a disciple of Aristotle and of Thomas Aquinas. He believes Freud's basic position to be that of anticartesian humanism, and he regards psycho-analytic theory as well fitted to serve as the central core of a universalistic conception of man.

The volume is divided into two parts. The first is concerned with the structure and functions of the nervous system, the mental apparatus and the dynamics of behaviour; the second is devoted to general psychiatry, i.e. nosology, diagnosis, therapy, and prevention, with constant emphasis on the unity of the psycho-physical organism.

The section on the nervous system deals mainly with those parts of the brain which are important for the study of behaviour. Freud is criticized for not having given sufficient thought to spiritual and immaterial, i.e. non-biological forces, but he came near to doing so in his concept of the unconscious part of the superego. Psychologists and psychoanalysts alike had neglected the study of intuitive and especially of religious experience. Krapf believes that man naturally tends towards the 'absolute good' and towards the ideals of goodness. He proposes a modification of Freud's dualistic drive theory. Instead of the destructive instinct he proposes the concept of paralibido, which aims at separation. He relates the two drives, libido and paralibido, to the sympathetic and parasympathetic nervous systems respectively. He believes that the preservation of life, the aim of all instinct, can be served by the connecting, i.e. libidinal, as well as by the disconnecting, i.e. 'the destructive' or paralibidinal tendencies. Paralibido aims at 'the tranquility of the person in his own company' and at withdrawal from dangerous objects by means of aggression or destruction. Instead of Freud's reality principle, Krapf postulates a 'principle of harmony'. Among other modifications of psycho-analytic theory is the concept of a matrocentric instead of the pregenital phase.

In his nosological orientation the author's approach is Jacksonian. He aims at determining what is happening in the nervous system. He sees the object of therapy in the improvement of symptoms by 'causal' treatment, but also in the improvement of 'causes' by symptomatic treatment. As in physical medicine, 'causal' and 'symptomatic' treatment ought to converge.

This is a stimulating and thought-provoking book, which students of psychiatry of all ranks and orientations will benefit from reading.

E. Stengel

The Self and Others. Further Studies in Sanity and Madness. By R. D. Laing. (Studies in Existential Analysis and Phenomenology.) (London: Tavistock Publications, 1961. Pp. 186. 25s.)

R. D. Laing, author of *The Divided Self*, attempts in his new work to explore the self within a 'nexus' of other persons. In his introductory chapter about 'the phenomena of phantasy' he evaluates critically psycho-analytical theories. He states that the validity of such mechanisms as conversion, projection, etc., 'postulated to provide a shuttle service between two worlds . . . rests on the validity of a very confused dualistic philosophy of psychical and physical, inner and outer, mental and physical'. But the hope that the author will develop less 'confused' concepts to replace these is certainly disappointed.

Laing deals at some length with the problem that no one can see through another's eyes or hear through another's ears, but has to draw inferences which are based on a number of assumptions. This process is hazardous, as the psychiatrist 'may simply step through the looking-glass into his own projected phantasy. . . .'. These well-known dangers are discussed by the author, because he postulates that existential analysis 'differs from this naive "natural" understanding . . . it is an attempt to understand the patient's being-in-his-world systematically . . . it is an attempt to do this in a self-critical way. . . .'. Laing quotes Mounier: 'The person is not an object that can be inspected, but is a centre of re-orientation of the objective universe.' The author obviously assumes that such a vague formulation should assist us in the certainly difficult task of understanding the 'other'—this is the term that Laing uses throughout the book—in the task of examining one's inferences critically, and at the same time not interfering with empathic understanding. The inferences that the analyst makes about the 'other's' experience are called by Laing acts of attribution. He does not mention the fact that verifications of such attributions might be achieved through the experience and consent of the other.

In the next chapter Laing again repeats descriptions, how every individual experiences the world in his own way, that two people looking at the same landscape do not have the same experience, etc. One cannot help feeling that from these cumbersome endeavours spring only self-evident notions, a knowledge which anyone with some psychological awareness and self-awareness must have acquired, if not earlier, at least in adolescence. But in the process of growing up one experiences that, although everybody lives in his own world, psychological understanding becomes possible by some quality in human beings; they share basic drives with each other and an ability and a need to communicate with each other, something for which different words have been created, such as empathy and so on.

All these long-winded discussions are introductions to an interesting problem that the author

describes: the possible conflict between the way an individual may see himself and the way he is seen by other members of his group, e.g. of the family. Laing suggests that individuals vary in their ability 'to shake themselves out of the phantasy system of a nexus'. Some persons who have never been able to extricate themselves from such a position live 'under a spell of an alienation effect'. Dissonant phantasy systems within the same nexus may put a person into an untenable position.

In the next chapter the author introduces the term 'elusion'. He quotes Sartre's description of a waiter who plays the role of a waiter, in this way denying the fact that he is really a waiter and the perception of it—a manoeuvre that Laing calls elusion. Such attitudes are typical for hysterics.

The chapter about masturbation is a part of the author's attempt to elucidate the role of phantasy. It ends with the conclusion that for 'some individuals masturbation can be the most honest act in their lives'.

Another chapter deals with a woman's puerperal psychosis, which consisted mainly in the phantasy that she was in the 'coldness of death'. Laing thinks that the description of her experiences in this state demonstrates 'the almost complete inadequacy of clinical psychiatric terminology . . .', and attempts to give a phenomenological analysis of the patient's experience. But in the course of these descriptions of different modes of experience the few points which might be really relevant for the understanding of the patient and for helping her, get lost. Her father and her brother had died, and in her psychotic state she identified with them. Such inner experiences as feeling of guilt and wish for punishment are not even considered. Should not an attempt have been made to understand and interpret her 'death' to her? Here again we may question whether the existential analysis adds to understanding or to confusion. At the end of this chapter Laing concludes: 'For practical purposes she was insane, but from an ultimate point of view she was no more subsane, no more moribund that we are most of the time without realizing it.'

In the following chapters Laing deals with different aspects of the mutual influence of individuals on each other within a group. It is unfortunate that he does not make it easy to follow his often interesting and valuable accounts, as he avoids, as if deliberately, certain terms, such as repression; he uses the term unconscious only very rarely and in quotation marks. The structure of the patient's personality remains vague; we have to learn his ideas like learning a language without the help of any grammar.

The most valuable part of the author's work and his most fruitful contribution appears to me to be the chapter on 'Collusion'. This term refers to 'a game involving mutual self-deception', instead of a relation in which two people may mutually confirm

each other or complement the other person. The problem arises where there is 'disjunction between a person's self-identity and his identity-for-the-other', and this disjunction cannot be mended by 'collusion', which would consist of confirming one another in a false position.

Laing emphasizes that Freud's dictum that analysis should be conducted under conditions of frustration is most meaningful as it refers to the patient's desire for collusive complements which the therapist should not fulfil. In this connexion the author writes: 'one basic function of a genuinely analytical or so-called existential therapy must be to provide a setting in which as little as possible impedes the patient's capacity to discover his own self'. Here again it is not clear whether this is just a self-evident statement about one of the basic conditions of an analytic process or a remark to point at a difference between existential and non-existential analysis.

In two other chapters the author discusses the 'Existential position as a function of the action of the self' and 'as a function of the action of the others'. An interesting example of Laing's thinking is his discussion of the exhibitionist. 'The man who does not reveal himself or is not "seen" by the others when he does, may turn, in partial despair, to false modes of self-disclosure.' 'The exhibitionist who shows off his body. . . may be despairingly trying to overcome that isolation and loneliness which tends to haunt the man who feels his "real" or "true" self has never been disclosed to and/or confirmed by others. . . . He can be substituting self-disclosure through this "thing" rather than through living. Analysis of such a person can show that it is not just this thing that he would have others gasp at, but him—the person—whose actions are "weak", "phoney", unreal, and impress no one. He wishes to put his would-be "true" self into his penis.'

A person can either put himself into a false position or can be put into a false position by the actions of others. Most fruitful appear Laing's discussions of situations in which a person, especially a child, is caught in a cross-current of contradictory injunctions which put him into an untenable position and may drive him into schizophrenic reactions. Here Laing, quoting other authors, gives examples of subtle contradictions in a mother's attitude between her words and her inner attitude which make a healthy reaction in her child impossible. In a chapter about 'types of ambiguous and incompatible attributions and injunctions' there are interesting examples of such interactions within a family nexus, in which the acts of one person are undermined and invalidated by the other person, e.g. if a child is ordered to be spontaneous and seeks to comply with the order by doing what is expected of him. Laing concludes: 'True guilt is guilt at the obligation one owes to oneself to be oneself, to actualize oneself. False guilt is the guilt felt at not being what other

people feel one ought to be or assume that one is, if this does not coincide with what one's own true possibilities are.'

It is difficult to do justice to this book. The use of vague concepts, the mixture of reformulations of old ideas and of really different concepts makes understanding and fair appraisal of the work not easy—it is a laborious task. Familiar formulations are abandoned and replaced by less concise terms, which are derived from a philosophical movement which in itself is full of contradictions. The potential value of subtle and perceptive observations of which Laing is obviously capable gets lost by his manner of presenting them. He seems to have been disappointed with psychiatric and psycho-analytic formulations. It is true that psycho-analytic theory, in its emphasis on genetic explanations, used to simplify matters and to neglect subtle nuances, seeking the basic drives in their multiple manifestations and vicissitudes. This question had become more noticeable with the widening scope of psycho-analytical applications from symptom-neurosis to character-problems. But the awareness of this trend has, for some time now, led to the growing interest in ego-psychology and its development within the framework of psycho-analytic theory. It also could be pointed out that psycho-analysis from the beginning has seen the individual under the influence of his family (the person in the 'nexus'). And to Laing's dissatisfaction with psycho-analytic concepts, one has to reply that these theories have been developed in an attempt to clarify psychological experience, to assist

us in understanding it, but not to replace experience.
Henry Lowenfeld

Fruition of an Idea: Fifty Years of Psychoanalysis in New York. Edited by Martin Wanh. (New York: Int. Univ. Press, 1962. Pp. 124. \$3.00.)

The oldest English-speaking psycho-analytic society, the New York Psychoanalytic Society, was founded on 12 February, 1911, and its Jubilee was therefore celebrated in the spring of 1961. The thirtieth anniversary of the foundation of the New York Institute on 24 September, 1931, was honoured at the same time. This volume serves to commemorate the occasion and consists largely of the speeches made at the celebration. It opens with an historical foreword by the editor, Martin Wanh, which reminds us of the immensely impressive contributions to psycho-analysis made by the members of the Society over the last half-century. Amongst the many interesting contributions Bertram Lewin's reminiscences, Victor Rosen's discussion of the relationship of the Institute to the community, Lawrence Kubie's comments on psycho-analysis and the American scene, and Jacob Arlow's speculations about the future are outstanding. There are a number of appendices and illustrations.

The New York Psychoanalytic Society deserves our warmest congratulations on its magnificent achievement during its first fifty years and our best wishes and high expectations for the next half of the century.

W. H. Gillespie.

ANNOUNCEMENT

Argentine Psychoanalytical Association

The annual symposium of the Argentine Psycho-analytic Association will be held on 14 and 15

June 1963. The subject will be 'Psycho-analysis of Anti-Semitism'.

23rd INTERNATIONAL PSYCHO-ANALYTICAL CONGRESS, STOCKHOLM, 1963

PROVISIONAL PROGRAMME

Sunday, 28 July. *Evening*: Welcome Reception.

Monday, 29 July. *Morning*: Plenary Session:

Official Opening

Presidential Address

Memorial to Marie Bonaparte by Rudolph M. Loewenstein

Discussion of pre-published papers on 'Symptom Formation
and Character Formation' by Jacob A. Arlow and

Jeanne Lampl-de Groot

(see pages 1-22 of this issue.)

Afternoon: Plenary Session:

Continuation of discussion of pre-published papers

Evening: Plenary Session:

(To be announced later)

Tuesday, 30 July. *Morning*: Seminars (in English, French, German, and Spanish):

Continuation of discussion of pre-published papers

Afternoon: Symposium on Fantasy

Section Meetings for individual papers

Wednesday, 31 July. *Morning*: Plenary Session: Business Meeting

Thursday, 1 August. *Morning*: Symposium on Homosexuality

Section Meetings for individual papers

Afternoon: Plenary Session:

Reports from Seminars on pre-published papers

Final Discussion by Dr Arlow and Dr Lampl-de Groot

Evaluation of the Congress

LOCATION OF TWENTY-FOURTH CONGRESS (1965) AND TWENTY-FIFTH CONGRESS (1967)

At the time of the 22nd International Psycho-Analytical Congress, held in Edinburgh in 1961, the Central Executive had only received one invitation for the next Congress. Although no formal action was taken, there was a general consensus that this state of affairs was not satisfactory. In addition, a suggestion was made to the effect that invitations and planning might in future be made four rather than two years in advance.

It would be appreciated if any group planning to invite the International Association to hold either the Twenty-Fourth Congress (1965) or the Twenty-Fifth Congress (1967) under their auspices would inform me as soon as possible.

Elizabeth Zetzel,
Hon. Secretary,
International Psycho-Analytical Association.

nate, until suddenly at a moment's notice the father would violently detach himself from L, scream at him, and force him to stand literally still until the position became unendurable. This pattern of play was never modified; it continued until the age of 5. L's subsequent life history elaborated the sequence of omnipotent victory and annihilating, self-inflicted defeats.

L's Case History as a Loser

I shall have to exclude many aspects of the analysis of this patient which are not concerned with the characterological aspects here considered. L entered analysis soon after returning from a Fulbright fellowship in France, where he had taught English to French children. This fellowship had been awarded him for his excellent showing in his main subject, English literature, at a first-rank college. He returned to New York for further studies for his master's degree, his curriculum permitting him to attend classes or not as he saw fit. His only responsibility was to pass a final examination covering the content of the course. He was also required to read a large number of set books on literature. His plan was to read each one of these in the given order and to know them in great detail. He also felt that he had to read every book written by each of the authors listed, although this was not required. The task he had set himself was impossible, the more so since the time limit was two years. Within two months, becoming deeply depressed and unable to do anything, he dropped out of school and then sought psychiatric help. A month later he began his analysis.

Within a few months L's depression slightly improved. He had always been interested in singing. At the age of 15 he collected records of the great jazz singers; his particular hero was Al Jolson. He had every Jolson record, and would spend hours listening to them, accompanying them with his own imitation of the singer, which was of extremely high quality. The analytically significant element in this situation was that he admired the great men of the past, whom he wished to emulate and surpass. This had been determined by his early preoedipal play with his father, as described above. L had continued his singing while in France, where he had joined an amateur opera group; and his interest in it was revived in analysis when his depression

was somewhat relieved. Through a pianist girl friend who accompanied singers, he met a professional baritone, seven or eight years older than himself, and roughly the same age as his brother, his only sibling. This man had achieved some uneven, modest success abroad, and had migrated to the States mainly to run away from his unresolved marital difficulties. Told by this man that he was a potentially great baritone, L began to study with him, knowing that he had never been a teacher. The pupil-teacher relationships were very loose. L soon developed fantasies that he would become a great singer, but these fantasies had very little realistic elaboration; in them he would never become a performing member of the Metropolitan Opera Company, nor would he sing any specific roles of any opera. His fantasy was that he was singing at the Metropolitan Opera House in a voice so powerful that it would 'shake the chandelier'.

During this period he had many dreams in which his teacher was singing on the stage and he was in the gallery. He was interchangeable with this teacher, and the next dream sequence would find him on the stage replacing the singer. In this relationship with his newly discovered teacher and patron (who had many ideas about his own greatness similar to those he attributed to his protégé) L often reversed the pupil-teacher role, and frequently guided his teacher not only on how to sing but also in his personal relationships. L seemed to take over his teacher's entire personal and professional life. This was quite similar not only to the preoedipal play, but to his adult relationship with the father. I once had the opportunity of seeing this interplay between father and son in my office. Since L was not working, the father paid for the analysis. The father occasionally asked to see me, ostensibly to discuss the patient's progress, but actually in a determination to interfere with the analysis, and to find out what he himself could do to cure the patient. On one such occasion the patient told me that he wished to be present. He felt on the one hand that his father might force me to give interpretations and evaluations that I would not give L directly, and on the other that the father might disrupt the analysis.

At the meeting the patient began by treating his father as if he were a child. He showed solicitude for his father's health, and examined his hands and scrutinized his face as if he

could find signs of illness. (The father had had a coronary thrombosis a few years earlier, but had been in good health since.) The father was totally submissive, as if the young man's behaviour were entirely proper and meaningful. But as the conference developed, the father became increasingly arrogant, obstinate, and finally reduced his son to a state of immobility and silence. The design of the preoedipal play was enacted once more.

To return to the progress of L's vocal career; he continued his studies with his young instructor. Eventually they came upon an older man, a former opera singer, who had recently turned to teaching. He was reputed to have been successful in Europe, but it was difficult to establish exactly what he had done. L and his former teacher became students of this man, who was also interested in reviving the techniques of the great singers of the nineteenth century. Again L took over the personal life of his new teacher, a lonely man in his sixties. He would cook for him, act as secretary for his badly organized teaching programme, and beyond this tried to formulate for himself the non-verbal, vague teachings that he was absorbing. He oriented himself as to the anatomy and physiology of the larynx and accessory structures in voice production. He began experiments in private with his own voice, which he used constantly and never rested. Finally, he injured his voice, developed a chronic laryngitis, and was medically advised to stop singing for six months; at the end of that time, feeling that he could never regain his original power, he abandoned his singing career. Again he felt defeated and became depressed.

He then revived another interest of adolescence, and began to become a great bowler. Once more the teacher who would make him great came along. He began to experiment with new techniques of impelling the ball, and devised new designs for its gripping holes. He made great strides in bowling and began to play in some top level amateur bowling tournaments. His interest in bowling dwindled when he reached a plateau.

Both bowling and singing were his interests as a teenager. When he was 16, he wanted to spend time as a pinboy at a bowling alley so

that he could earn enough money to play as often as possible and improve himself. His father interfered with this ambition, and offered him sums of money just for play, discouraging him from working for it. When at college he wanted a jalopy, his father offered him a brand-new car. When he wanted to become a teacher, his father belittled this interest and urged him to become a business man, particularly in his own business. When he was about to go to Europe on his Fulbright, his father arranged that an influential friend, the vice-president of a bank, should intervene and try to discourage L from going.

After graduating from college, L lived away from home, visiting his parents about once a week. Whenever possible he would play pinochle with his father. This game also showed the same pattern. At the beginning L would seem to be winning, but soon his father, an expert at cards, would reverse the roles and beat the son decisively. L would be furious and leave in a huff, but was always convinced he would beat his father the next time. It is significant that the father would play cards all day, every Saturday and Sunday; this had been his main hobby from adolescence. At that time he used to play for very high stakes with semi-professional gamblers, among whom was an older man who introduced his daughter to L's father; she eventually became his wife and L's mother. L's maternal grandfather and father were neurotic gamblers, exemplifying the characteristic, deep-rooted father-son conflicts and longings for omnipotence. It was expected that the preoedipal play between L and his father would be similar in psychological content to that which is found in pathological gambling.²

During his adult life, L always chose activities that emphasized manual and physical achievements. He wondered why this should be so, since he had an extremely high I.Q., was very well read, and had done well at college. He could have used any of these areas from which to carve out a successful career. He became aware that physically oriented activities fulfilled his fantasies of becoming great. The chosen activities were such that he looked upon himself as having little native ability or endowment in these areas, and he

² Freud, in his study on 'Dostoevsky and Parricide' (1928), analyzes the neurotic gambling situation as a father-son conflict in which strong yearnings for omnipotence are mistaken for omnipotence. Greenson (1947)

has elaborated on the 'gambling' neurosis as a challenge or testing out of the father figure wherein to win is to share in the father's omnipotence and to lose is to be rejected by the father.

imagined himself, in spite of the handicap, going on to great heights where he would outdo the champions and masters, past and present, in their fields. It became clear that these activities were rooted in his childhood development extending back to his pre-oedipal play with his father.

L remembered that, when he was 4 or 5, his father would frequently come into the bathroom while he was urinating. His father would take out his own penis and make a game of criss-crossing their urinary streams into the toilet bowl. This was as routinized in their relationship as 'playing cards' was later on. L noted how much larger his father's penis was than his own, and felt that he wanted his to be as large and as powerful immediately. He was never made to understand that the difference was temporary, and that eventually his penis would grow. His father played this game and others as if the present would continue for ever, and L had to try to win with what he had. L would aim his stream at his father's and desperately strive to give it a force that would deflect the other; but when it did, his father would deflect L's stream with even greater force. L reacted to the penis of his brother, who was eight years older, in the same way as he did towards that of his father.

During an analytic session, L re-experienced a symptom of depersonalization from which he had suffered recurrently since childhood, but which he failed to recall in the four years of his analysis. While on the couch, with both hands tucked under his head, he complained that his left hand felt almost as big as the room, and his right hand, directly underneath the left, felt tiny and fading. He recalled that he had periodically experienced such unpleasant episodes since the age of 5, particularly when he had been ill and confined to bed. He now connected these experiences with the urinary games with his father. His position on the couch, with both arms ending in hands crossed under his head, preserved in body images of himself the memory of the criss-crossing urinary stream of father and son. This made clear to him to what gigantic proportions he had distorted his father's larger penis and reduced the size of his own.

When L was 8, he strove desperately to beat his older brother at table tennis. Good as he was at that age, such a victory was impossible.

When his brother played with his left hand,³ L would occasionally win, and on such occasions he became ecstatic, ignored the significance of the handicap, and viewed it as a total victory. When in his late teens he would beat his brother, but he was no longer excited. He had to win in the self-image of being small, weak, and incapable. Subsequent activities, such as card playing with his father and betting on bowling matches, were more suitable outlets for these needs.

L's father took over not only his urinary function, but also his bowel training at a formative age. At 3, L suffered from severe constipation, and the family consulted many paediatricians. His father felt that only he could handle L's difficulties. Each night after work, L would be put on the toilet seat. The father would put a penny on the floor, equidistant between them, and the game was to hit the penny with a rubber ball. The father's idea was that L, happily distracted by the game, would overcome the fear and pain of trying to move his bowels. L had occasional success with his bowel movements, perhaps when his father allowed him to win. The overall outcome remained unclear as to whether L had achieved a successful solution of his bowel difficulty or of the throwing game. It is clear that the bowel movement game had the same quality as the urination game, and that both had their origin in the earlier pre-oedipal play when L would climb all over his undefending father, who would then retaliate with a severe thrashing and force L to stand motionless for a long period.

L's sexual behaviour during puberty and adulthood followed the same pattern. During puberty he masturbated, apparently unconcerned with the customary guilt, until he incidentally developed herpes on his penis. He ran to his father, who prior to this had made unheeded references to the ill effects of masturbation. He was taken to the family doctor, who, perhaps at the father's suggestion, attributed the eruption to masturbation, which the boy then for a long time abandoned. He did not have intercourse until after he had entered analysis; when he did, he undertook it in grand style. He invited his girl to his apartment for dinner, served with Italian wine in a candle-lit atmosphere. He approached her in the character of a sophisticated, strong-

³ This brother's left hand was represented in the body image symptom of the gigantic left hand. The left hand

stood for the paternal penis, shared by his father and brother; the diminutive right hand represented his own.

willed lover with much *élan* and experience. Subsequently his sexual interest dwindled, and he returned to his former non-sexual relationship with the girl, alternately being consoled by her for his inadequacies and playing towards her the role of father, guiding and counselling her much as his own father had done for him.

Early Play in Father and Son 'Winner' Relationship

When W (the winner) had been in analysis for a year, he introduced his worries about his oldest child, a 3-year-old girl, who he felt was over-aggressive, like himself. He felt wholly responsible for this, and went on to explain how in the last two years he had constantly played with her in a special way, which he now thought had been harmful to her. During her first year of life he had interfered with her normal desires to reach for and possess objects. Like most infants, she would be attracted to various objects, but as soon as she moved towards one, W would move it away from her, and as she persisted in trying to reach it again and again, he would put it further out of reach. The baby became increasingly frantic, cried and screamed. W would then hold the object tightly in his hand; she would be permitted to grasp it, but not to take it from him entirely. Finally, when she was completely beyond control and attacked violently, he would permit her to pull it away from him, and would then smile at her in approval of her persistence and accomplishment. In one form or another, W had continued this type of game with his daughter until she was 3. After the working through of his own aggression, he was now able to expose this behaviour and modify it. He felt that he had designed this play with his daughter almost consciously, to prepare her in life to be aggressive and to be a winner.

It soon became clear to him that this was unconsciously determined, and he remembered that his father had played with him in much the same way as far back as he could recall.⁴ He would be thwarted and angered by his father in seeking to gain anything he wanted, and then would violently and surreptitiously seize it, with his father's subsequent submission and approval.

W's Case History as a Winner

It is not surprising that, when W was in his early twenties, he went into a speculative business adventure to which he was attracted. In this he was joined by his father, who provided part of the necessary capital, after much haggling and imposing great suffering on his son before giving him the money. The business soon grew by leaps and bounds. Arrangements had been made for a partnership with equal sharing of the profits. Since the father was merely a major investor and not an active participant, W rationalized that his self-declared decision to consider his father a minor member of the firm was justified. Without mutual agreement, he continued to give his father a very small share of the accruing profits. His father, in spite of his love for money, having had a reputation as a hard business man, accepted ungrudgingly his son's uneven distribution of the profits and, of course, was unconsciously pleased, as he had been in the original preoedipal play.

W had taken part in many business ventures since he was 20, all of them of the same general nature. He always had his own ideas and objectives for any business adventure. He would seek out an older man who, he felt, knew more about the new field than himself. He would aggrandize his newly-found partner, claiming that the older man held the key of knowledge as to how to succeed; he then felt he had to get that knowledge away from such father substitutes. Finally, he would go into business with these men and then set about depriving them of their promised share, ousting them from the business, to which he would hold on as sole owner.

In all instances he attempted to preserve a social and protective relationship with these former partners. As with his father, he would give them small stipends, either out of the business itself or as a charitable gesture. In two instances he made pimp-like procurers out of his former associates. He gave them unearned money which was to be directed towards finding girls for W to sleep with. The procurers would either pay the girls for their services to W, or give them gifts and promises of help in their careers on the stage or as models. W tried to deny to himself that these girls were being rewarded by his own money,

⁴ Coleman *et al.* (1953) in their study of variations of early parental attitudes, noted that 'parents as analytic patients find access to repressed experiences of their own

childhood by living with their own children, by observing them, and by reacting to them'.

and fancied that his former partners loved him dearly and were accidentally discovering young girls who would find him attractive.

W's first marriage at the age of 20 embodied the entire content of his preoedipal play with his father. Once again he had an idea for an original business which necessitated renting a store of considerable size in his own neighbourhood, which he could ill afford to do. This property was owned by a widow, who had a daughter of suitable age for himself; he had shown some mild interest in this girl in the past. With his intense desire to get the store at a modified rental, he began to court the girl. The indispensability of the store and the widow's help were projected on to the feeling of the girl's indispensability. He felt he might be in love with her. Of course, this pleased the mother, herself a tough business woman, who unconsciously represented his father, and she, like the father, now held the desired object. He rented the store on the most favourable conditions, and the relationship with the daughter led to marriage.

W's business boomed, and for the first time he amassed a considerable amount of capital, which made it possible for him to seek out new and larger businesses of the same kind. Simultaneously he tried to rid himself of his wife and mother-in-law, who had now for some time been useless to him. Obviously these relationships were more difficult to sever, since not only did they involve moral and other complicated ties within marriage, but both he and his wife were active Catholics, as were the other members of both families. In spite of the fact that divorce was unheard of in W's family and in the Catholic community, it had to come about—and it did.

His courtship of his second wife was used to extricate himself (with a deliberateness like that of his business ventures) from his first marriage. He managed to impregnate her and insisted that she go through the pregnancy. He then introduced her to various members of his family, who were forced to accept his solution that he should divorce his former wife in spite of the religious problem. Since he was uncertain whether his new wife had married him for love or was forced to by the pregnancy, he made her repeatedly pregnant, so that they had three children in the first three years of marriage. His calculating thought was that she would be fully occupied with three children and a new home, and would not be in a

position to entertain any conflicting feelings about her love for him.

His childhood had been studded with precocious aggressive victories. When he was 6 years old, he began helping his father in his grocery business, being aided by his younger sister. One day the father noted that the two children had much more money for candy than he allotted them. He coaxed W to tell him where he had obtained the money, with the promise that the boy would not be punished. W confessed that he had devised a scheme for taking empty deposit bottles which had already been returned to his father's store, and redistributing them to his playmates, who would return them to the store and be reimbursed by W from the till. He would then collect the money from his friends and share the spoils with his sister. His father kept his word and did not punish him; it may be supposed that he secretly admired and sanctioned his son's trick, which revived the same kind of game that he had played with W at the age of 2.

At the age of 8, when sitting in his father's lorry, waiting to assist him with deliveries, W began to masturbate and was suddenly confronted by his father, who again said nothing. When W was 9, during the war, his father was doing some minor cheating with food ration coupons which permitted him to make some extra sales. W knew of this and managed to steal so many food coupons that discovery would have led to a criminal prosecution. He handed over the coupons to his eldest brother, who was then 20. The brother reported this to the father, who became frightened and told the sons to destroy the coupons and not take any chances. The father never acknowledged that he knew W had stolen them and, of course, never admonished him. Again we can reconstruct that the father admired W's over-aggressiveness, and felt secretly pleased that his son was shaping up in line with his early efforts and aspirations.

When W was 12, a 16-year-old boy made a derogatory remark to him about his father. W knew that the other boy, a head taller, could easily overcome him. He pretended to walk away, then suddenly lunged at the bigger boy with a fierce blow at the face, quickly grabbed him in a headlock, held on, and thus injured and defeated him.

During adolescence he resolved the problem of his future career. Since he was highly

intelligent and able to do well in academic subjects, his teachers at his first school urged him to continue his studies and to consider becoming a priest, which would also have pleased his mother. His struggle reached its climax during his first year at college. He became engaged in a number of business activities which attracted him, demanded his attention, and were highly successful. He dropped out of college and pursued the business world, which offered him more satisfactory outlets for his over-aggressiveness and provided him with enough situations to act out repetitively his overdetermined pattern of passive submission to the father followed by aggressive annihilation of the paternal object.

The design of the preoedipal play with the father continued into the resolution of his oedipal conflict. The acting out of complete submission and complete annihilation of the father led to a pattern of overt male bisexuality. Throughout his adolescence there were episodes of homosexuality associated with violence which coexisted with heterosexual activity. Gradually the overt homosexual component of his sexual activity was redirected into his business activities.

Discussion

Freud (1916) noted the tenacity and deep-seated origins of character types met with in psycho-analytic work. He accounts for the character formations (of exceptions, those wrecked by success, and criminals from a sense of guilt) on the basis of unresolved conflicts in and around the oedipal period. Generally speaking, psycho-analytic literature and theory as to the father's contribution to the child's development have concerned themselves only with the oedipal phase. The characters of the 'winner' and the 'loser' are based on conflicts that arose during the preoedipal period, in the specific form of play between the fathers and their respective sons.

In such preoedipal play, numerous pathological consequences can be anticipated. Some of the more important pathological deviations will be considered here: (1) the distortion of the ensuing oedipal conflict with a regressive love object on a regressive instinctual level; (2) the faulty development of object relationships; (3) the pathological fate of the aggressive and

libidinal drives; (4) the permanent effect upon the ego-ideal and ego identifications; (5) the reinforcement of the repetition compulsion which promotes a permanent state of acting out, leading to the pathological character formation, as in the cases of the 'winner' and the 'loser'.

The two character fixations are not the only possibilities that result from pathological preoedipal play between father and son or daughter.⁶ There are many other resolutions of pathological preoedipal play between father and son. For example, a patient in analysis, the father of two grown sons, reported that when his older boy was about to learn to walk, he would permit him to crawl to the unprotected edge of the bed and encourage him to fall so that the child would learn very early that if he was active or exploring he should expect to be hurt. This fitted in with the father's conflicts of fear of activity which provoked intense anxiety and passivity. When this son was 24, he was a bearded beatnik who enjoyed hunting, skiing and motor cycling, but had never lived away from home. Any of the adventurous activities might be carried out during the day, but night found him back home in his own bed. There was every indication that this state of affairs was not going to change, and that the pseudo-adventurous young man would remain the child at home for years to come.

1. The Nature of the Oedipal Conflict

In pathological preoedipal play between father and son, it is assumed that the nature of the earlier object relationship predetermines the oedipal conflict. This is certainly true in overt male homosexuality, where the preoedipal identification with the mother is merely continued on to the time of the oedipal conflict and the male child remains identified with the mother, unrelated to whether the father is forbidding in the oedipal conflict. The preoedipal identification with the mother is the stronger determinant for the negative oedipal solution (Weissman, 1962).

This is true in the cases described. L, in his sexual behaviour, would have transient relations with a woman and would then abandon his position. This was clearly illustrated when L was studying voice production with his second teacher, the older man. Among his pupils was an attractive woman in her late thirties (almost ten years L's senior). L became sexually attrac-

⁶ We can readily imagine that such play with a little girl might lead to special character derangements as influenced by the female's universal and insoluble problem of penis envy. The subsequent sexual role of

the father in the oedipal conflict would produce a different type of character resolution from that in the male child.

ted to her, but feared he was competing with the 60-year-old teacher who, he felt, was interested in her. He exaggeratedly felt that she was his teacher's property, and had the unlikely fantasy that the old man was having intercourse with her. L had a sexual affair with her which was short-lived for fear that the teacher might punish him by improper vocal instruction if he found out. He continued an intimate friendship with the woman over a period of years, helping her financially and with her voice. He became increasingly submissive towards his teacher, would clean his house, cook for him, and drive him about. There was at no time a sexual or personal relationship between the old teacher and the woman. In the final analysis, it was the design of his preoedipal play which characterized this Oedipus-like situation. He first sexually conquered the older woman whom he designated as the property of the older man, his teacher and father-surrogate; he then withdrew to a passive position towards the older man, as in his childhood play with his father. His self-inflicted submission was based on a pregenital fear of catastrophic annihilation by an omnipotent parent rather than a castration threat from an oedipal father.

The extension of the preoedipal play with the father had its counterpart in oedipal conflicts for W in the same way. W would frequently take his father on business trips to Europe and the Orient. His father had little to do but witness W's extramarital sexual escapades, silently and not disapprovingly. To conduct himself freely while his father was about increased W's pleasure. Numerous examples in the lives of the 'winner' and 'loser' indicate that the specific pathological resolution of their oedipal conflicts followed the resolution of the preoedipal play between themselves and their fathers. This is also illustrated by the presented data which deal with the fathers' attitudes towards their sons' masturbation.

II. The Nature of Object Relationships

In spite of the fact that W and L had achieved a state of overt heterosexuality, the more significant and involving object relationships throughout their lives were with men. W was constantly preoccupied with schemes for new business adventures in which he could annihilate older men; the aftermath was usually a celebration with extramarital intercourse, which left him bored. He used his first marriage as an

auxiliary to the promotion of a business deal. He used fatherhood and his second marriage to extricate himself from his first wife and a local business.

Similarly, L's heterosexual activity was abortive and secondary. Primarily he was involved in a lifelong struggle to bring about an omnipotent illusory achievement—as a boy to be more powerful than Babe Ruth; as a young man to shake the chandelier of the opera house and beat his father at card games—in fields of activity which he approached unrealistically.⁶ The unfortunate aim of his life was to excel his father (and his father's penis), which was first encouraged and then defeated by his father in the preoedipal play.

While both fathers were domineering and overwhelming from the first year of their sons' lives, it was characteristic of both mothers to play secondary roles in the development of their sons after the first year of life. The two mothers had in common a limited capacity for object relationships. They had few, if any, personal friends or personal interests, and seemed to live completely in the shadow of their husbands' glory. As mothers, they had a highly developed capacity for nurturing and feeding. Their roles as mothers were well fulfilled in the first year of their children's lives, and thus both W and L had affectionate, loving feelings towards them. But these women seemed ill-equipped to contribute to their children's subsequent development during the anal and phallic phases and the concomitant expansion of the ego. In many studies of early good or bad relationships between mother and child, one fails to see an evaluation of the mother's strength and weakness as she affects different stages of early development (Coleman *et al.*, 1953). Thus, a mother who feeds her offspring well may play with him ineptly. W and L had no further elaboration of their relationships to their mothers as they approached the oedipal period. Their relationship to the mothers remained undeveloped beyond an oral level, while the relationship with the fathers became accentuated and over-involved in the preoedipal period. Neither mother tended towards playing with the child or reading to him. All this contributed to distortions in instinctual development.

III. The Fate of Aggressive and Libidinal Drives

In the pathological preoedipal play described above, the normal development of aggression

⁶ Bergler (1942-43) views neurotic gambling as a rebellion against the reality principle.

was distorted. L was encouraged to treat the infantile phase of omnipotence as if it were an everlasting reality. His father first permitted him to be aggressive and omnipotent towards himself and the household. (L was wont to throw any handy object at any intruder on his privacy, but would then suddenly be violently punished.) The next moment he would be made to feel small and deprived of his powers.⁷ This parallels the early concepts of the normal small child in whom omnipotence is attributed alternately to the self and the parent. In L's case, this concept of omnipotence was perpetuated from then on to the present as reality.

W was an active, alert infant whose qualities so intrigued his father as to cause him to ignore his other children who had less of them. He over-stimulated and deflected W's normal infantile development of grabbing attractive objects. He made them hard to get, temporarily frustrated him, gave these objects more value than they would ordinarily have, and finally spurred W on to violent aggressive behaviour in order to possess them. This play continued throughout W's subsequent development on to the oedipal period, and the aggressive possession of the object became more and more sexualized and never neutralized.

The lack of opportunity for normal libidinal development for both W and L is self-evident. W's libidinal development was directed towards the exclusive pursuit of attractive inanimate objects; money and power became his dominant libidinal gratifications. L's libido was fixated on pursuits in which the aim and object were annihilation of or by his father. With the secondary roles their respective mothers assumed, there was little opportunity for libidinal development (beyond the oral level) towards a genital object relationship with women.

IV. Pathological Preoedipal Play and the Repetition Compulsion

Freud (1920) illustrated the presence of the repetition compulsion in the case of a 1½-year-old boy. As I have said elsewhere, Freud, in this era, had to explain phenomena of ego psychology

in terms of instinctual psychology (Weissman, 1956). Subsequently it has been shown that the early normal play of infants and young children in the preoedipal period is inherently repetitive in nature and is the ego's attempt to organize the environment. Instinctual phenomena have, according to Kubie (1951), an instinctual repetitive quality. Kris (1954) has commented on the important problem of determining when play ceases to be merely play and becomes evidence of pathological regression.

Since the overstimulating and consequently ego-traumatizing play in the cases described began early in the preoedipal period, it is not surprising to find that the play continued in a repetitive, compulsive fashion throughout their lives. In both cases, the non-neutralized aggressive and libidinal play was the unconscious force in the majority of the activities undertaken by the 'winner' and the 'loser'. The design of the unmodified drives of the preoedipal play was constantly repeated in the subsequent development of their lives. Eventually the loser developed into a young adult who pursued his various interests of sport, education, and singing with an initial infantile ambition of illusory paternal omnipotence which, when realistically pursued, had to fail because of its unpractical, undefined and unachievable aims. The 'winner' became a highly successful business man who never enjoyed his success and was never satisfied. He remained driven by the prospects of new businesses and schemes in which his transient aggressive pleasure was to submit passively to an older man whose possession he finally wrenched from him.

V. Permanent Effects on the Ego Ideal and Ego Identifications

Freud's example of repetitive compulsive play is one of a child's self-initiated play.⁸ Our examples of play were externally initiated and directed by the fathers, and as such have more permanent effects upon the subsequent character development of the child. Since the play with the fathers was underscored by their unconscious attitudes towards their sons, it served to develop

⁷ Schilder (1942) compares the phenomenon of failure to a neurosis. In a series of cases, all males, he finds that the father plays the paramount role. While Schilder suggests that parental attitudes of exaggerated admiration combined with outbursts of aggression and severity are particularly dangerous to the development of failure in the offspring, he does not clarify at what stage of development or in what specific activities these attitudes become crucial determinants for the subsequent development.

⁸ Children's play, in whatever form, is a principal vehicle for various psychological phenomena. Be it self- or externally initiated, play may be ego-regulating, as in traumatic episodes. Play may be the format for the aims and objects of drives and for the defences. Play may serve as a maturation process for the psychic structure into its more final definition of superego, ego, and id, corresponding to environmental and developmental factors of the given moment (Weissman, 1956).

vital identifications with the fathers and to form early models for lifelong ego ideals.

W's father intended to mould his son into an aggressive 'winner'. It is apparent that such an ambition for a child finds its habitat in the formation of the ego-ideal. During the analysis, as W began to modify his over-aggressive behaviour, he suffered from a sense of loss of self-esteem. He worried about whether he was slipping and becoming soft. It could be demonstrated that such a feeling of self-evaluation came from the idealization of the father.

L's ego-ideal was more complicated. He suffered from loss of self-esteem when he could not achieve an illusory, omnipotent status. He also suffered from helplessness, insecurity, and dependence on his father, who was also idealized as omnipotent and omniscient. The anlage for the respective ego-ideals of both W and L was precipitated out of their respective preoedipal play with their fathers. Coleman *et al.* (1953) have emphasized that the paramount determinant in the reactions of parents towards their children is to be found in the tendency to identify with one's own parents. They write: 'This identification may manifest itself in behaviour ranging from compliance with the parental model to protest against it, and these tendencies may range from complete unawareness to full consciousness.'

VI. Development Effects of Preoedipal Father-Son Relationships

The subject of early, preoedipal relationships with the father as crucial determinants in the subsequent development (with particular emphasis on the childhood of the artist) has been dealt with by Greenacre.⁹ She accounts for the phenomenon of penis awe as occurring from the second year to the fourth-fifth years of life and considers such experiences to be 'dependent in most individuals on the actual seeing of the adult tumescent penis at a time when the child himself is in a particularly sensitive state'. According to her (1956), the experience of awe is 'evident in many clinical studies of less

gifted individuals, as well as in the autobiographical statements of artists'.¹⁰

The early development of the 'winner' and 'loser' clearly shows evidence of the experiences at the time of the 'second year and fourth-fifth year' of life, which indicate a more intensive involvement between father and son on matters of seeing and being given or not given the father's penis. Both L and W experienced the pathological play with their fathers during the second year of life. In view of the special relationship established by the intensely repetitive play between father and son, we could reconstruct that both L and W experienced during the second year of life overwhelming reactions to the sight of their fathers' penis. The urinary games between L and his father, at the age of 5, were extended into depersonalized split body images of Gulliverian gigantism and Lilliputianism which were accompanied by overwhelming affects made up of ecstasy and anxiety. When W was 4, he was forced to touch the penis of a 14-year-old boy (his older brother's friend); he reported this to his father, who threw the older boy out of the house and gave W a feeling of ecstatic victory over the older male.

Freud once said (Loewenstein, 1960) that the development of unusual ability and achievement is encouraged in a son who reaches superiority over the father in childhood, if the father wishes it and accepts it. W's father not only accepted it; he prematurely strove for it. While the cited examples of gifted lives emphasize the affirmation of successful identification with the father, similar to the case of W, there is no reason to seek a further explanation for L's character trait as a 'loser' than his father's failure to permit his child to identify with his omnipotence. This was the crucial factor in shaping the identification of the loser, which L lived out.

Conclusion

Specific preoedipal play between fathers and sons has been described as the principal determinant for the final development and character traits of the sons. The play, initiated by the

⁹ Greenacre writes (1957): 'It may be that the identification with the father—or with a specially god-like father—begins at this time (second year and to the fourth-fifth years) and is felt rather regularly due to the combination of the sharpness of the body sensation with the intensity of the sensory sensitivity to the outside world'.

¹⁰ Kris (1952), in his chapter on 'The Image of the Artist', cites the case of the young sculptor who associated the fantasy of the sudden appearance of his talent with the content of a dream 'of being given a real,

i.e., a fully grown penis by the father image of his discoverer. The matrix from which this fantasy evolved was the old competitiveness with the patient's real father who had been successful in the same branch of art.' More recent psycho-analytical studies (Eissler, 1959; Weissman, 1957) of specific lives of highly creative people (e.g., Goethe, Stanislavsky, *et al.*) confirm the significant period in the childhood of the artist when the father 'fulfills the need for the model with which to identify'.

fathers, embodied the fathers' fundamental conscious and unconscious orientation towards these children and was derived from their own unconscious childhood fantasies stemming from identification with their own parents. Such types of pathological preoedipal play signify a severely pathogenic parent-child relationship in which the child is the object upon whom the parent gratifies his own pregenital, unneutralized drives, resulting in serious disturbances in every area of the child's subsequent psychological development. The established pattern of play in the cases described resulted in crucial consequences for the subsequent development and maturation

of their libidinal as well as aggressive drives, their object relations, preoedipal and oedipal conflicts, and their ego and superego identification with their fathers. The ultimate characterological traits in adult life represented a continuation of the original play, transformed by acting out and preserved by the repetition compulsion. Finally, the qualities of their mothers leave unresolved the problem of how different the development and character of the sons, given the same fathers, would have been, had their mothers been able to participate more consistently and favourably in the subsequent development of their children.

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SOME OBSERVATIONS RELEVANT TO EARLY DEFENCES AND PRECURSORS¹

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The earliest phases of life have always engaged the devoted study of psycho-analysts, while eluding precise exploration by the psycho-analytic method. The period of the individual's life before he could speak is, as it were, submerged in the water of the primary process with its ambiguous opacity and fluid movement. As we try to see deeper, more and more reconstruction, extrapolation, and compounded hypotheses from the data at hand become necessary, and we begin to falter. In spite of all the difficulties we know there has been progress. The child analysts and those analysts who have been particularly interested in borderline cases have made contributions too numerous to mention. Certain refinements of the first insights of Freud have been gradually emerging. Psychic institutions had first to be identified, and only later could their well-springs in biology be understood: their maturational sequences, their 'taming' (in Hartmann's (1939) sense) and their 'phasic ascendancy' (Greenacre, 1952, 1954, 1958).

Each aspect of development is being subjected to scrutiny along these lines, which we call the genetic (or 'epigenetic') point of view. We may mention the theory of libidinal development (Erikson, 1950) cognitive processes (Rapaport, 1950, 1951b; Schur, 1953, 1955, 1958, 1960a, 1960b; Wolff, 1960); self and object representations (Jacobson, 1954); the theory of instinct and affect (Kaywin, 1960; Schur, 1960b); superego (Sandler, 1960; Schafer, 1960); and pathological processes generally (Glover, 1956; Menninger, 1954).

Most psycho-analysts who work in the area of early defences refer to psychosomatic illness as a fertile source of data regarding the development from primary to secondary processes (Gitelson, 1959; Glover, 1956; Greenacre, 1952, 1954; Kaywin, 1960; Rubinfine, 1959). Some data

concerning linkages between words and physiological processes will be reported which are relevant to stages in which bodily precursors of defence evolve into psychic defences and verbalizations. Since this material is not available in psycho-analytic journals, it will be summarized. What appears to be involved is what Jacobson (1954) has called 'the pathological partial retransformation of ideational and emotional into somatic physiological expression', or what Schur (1955) refers to as 'resomatization'. Since the research shows a regular relation between the specific ways in which people speak of difficult times in their lives just preceding their illnesses, on the one hand, and specific physiological processes and diseases, on the other, we must take a passing glance at the specificity problem. This has long been an obstacle to the use of psychosomatic observations by psycho-analysis.

The trouble with specificity theory generally seems to centre around the attempt to establish relations between highly organized constellations of personality traits—of fantasies, drives and conflicts, even of an entire neurosis or character deformation—and disturbed physiological processes: the complexities to which this gives rise have been elaborated at length (Bonaparte, 1960; Deutsch, 1953; Gitelson, 1959; Glover, 1956; Greenacre, 1952, 1954; Kubie, 1953; Schur, 1955). But if instead we look for the key to psychosomatic illness to a large repertoire of responses possessed by all individuals of the species, biological 'givens' of the undifferentiated state, such as blushing, crying, piloomotor erection, lachrymal secretion, etc., and their use as precursors of defence, the problem of specificity changes character. The relevance of an individual's neurosis or character disorder to a psychosomatic illness then becomes one of successful

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adaptation or failure under stress, and of the proneness to regression. The result of decompensation is the resomatization of defence, affect and anxiety response, along with other manifestations of ego failure (Schur, 1955). Evidence is accumulating that decreased ego strength and increased bodily disease go hand in hand (Rapaport, 1951b), that such diseases are usually multiple (Buck and Hobbs, 1959), and that adaptive functioning in many areas is impaired before the outbreak of disease (Hendrick, 1953).

A disease symptom, however, is the result of the specific reaction to immediate specific stress, and need bear no more specific relation to the neurosis which has given way than tears do to the total complex of internal processes preceding the appearance. This is a concrete, not a global, view of specificity. It is in the tradition of Claude Bernard's views of the nature of disease processes in general, and Karl Menninger's (1954) application of these views to psycho-analytic theory in particular: disease is the result of the organism's failure to maintain homeostasis in the face of stress.

The Specificity of Attitude Research

In 1952 Grace and Graham published a study of 128 patients suffering from psychosomatic illnesses. They had noticed, after listening to a considerable number of patients, a remarkable similarity among persons with the same illness: the words they used to describe their feelings about the important events in their lives which occurred just before the onset of their illnesses were nearly the same. It was possible to reduce these descriptions to a simple formula, which they called an 'attitude'. This has two aspects, one expressed in words and the other in physiological processes. The verbal statement has two parts also; expressing what the individual felt was happening to him and what he wanted to do about it. Grace and Graham suggested that there was a specific relation between the attitude towards a stressful life event and specific disease processes. Subsequent research (Graham *et al.*, 1958, 1962a) extended the number of diseases and associated attitudes, but this is by no means exhaustive, for it depends on what we call a disease. The relation between the statement 'I felt embarrassed' and the condition of blushing (a 'shame attitude') is clear, but blushing is not considered a disease.

At first sight, this hypothesis arouses considerable resistance in the analyst. It is too simple, and apparently takes no account of hard-

won knowledge of defences. The attitudes are at once too superficial and too deep. There seems no probable relation between such conscious statements and deep disturbances of homeostatic regulation. Also, we look for genotypes behind phenotypes—cultural, educational, and many other individually idiosyncratic factors are not taken into account. They seem too deep, in that analytic experience would not lead us to expect the undefended immediate statement of a dynamically vital mechanism in a non-psychotic individual. These objections lessen as we understand the nature of the processes at work.

To prove the hypothesis, controlled research was carried out, using rigorous design, employing objective methods of selecting patients, interviewing, and judging interviews. Two studies of ten attitudes (Graham *et al.*, 1962b) showed that the patient does state the expected attitude, that objective judges can identify it in carefully edited interview records, and that all judges could do this even when the interviews were conducted by someone ignorant of the hypothesis. Statistically significant results were obtained (P values less than .01).

There are two critical objections to be dealt with, which we will designate, for convenience, the 'existential' and the 'unconscious cue' problems. Turning to the first, we could argue that these results only confirm a relation between a 'diseased' point of view, expressed verbally, and a disease. This argument loses some force if we try to guess the disease, *a priori*, by looking at the attitude and, in the case of diseases which have marked ups and downs, even when the patient is asymptomatic he will express typical attitude statements about past stress leading to past exacerbation.

It is true that patients often come to express themselves in specific attitude terms when talking about their symptoms, especially when these have existed for some time and are known to the patient. Hypertensives come to regard the symptom as threatening, but they can do this only after their doctors have made them aware of the blood pressure elevation. Ulcer patients feel deprived of the pleasures of life by their disease and their treatment. Colitis sufferers feel degraded by colitis—they have (to use one patient's words) been 'shafted' by their illness, and inevitably by their proctologists. The circularity of such a development is apparent and has ominous bearing on chronicity and severity. Others have commented on this type of phenomenon in psychosomatic illnesses, among them

TABLE I

VALIDATED ATTITUDES

Ulcerative colitis	Felt he was being injured and degraded and wished he could get rid of the responsible agent (was being humiliated, 'screwed'; wanted the situation to be finished, over and done with, disposed of.)
Eczema	Felt he was being frustrated and could do nothing about it except take it out on himself. (Felt interfered with, blocked, prevented from doing something, unable to make self understood.)
Asthma and hayfever) (vasomotor (rhinitis)	Felt left out in the cold and wanted to shut the persons or situation out. (Felt unloved, rejected, disapproved of, shut out, and wished not to deal with the person or situation, wished to blot it or him out, not have anything to do with it or him.)
Hyperthyroidism	Felt might lose somebody or something he loved and took care of, and tried to prevent loss of the loved person or object. (Tried to hold on to somebody loved and taken care of.)
Duodenal ulcer	Felt deprived of what was due to him and wanted to get even. (Didn't get what he should, what was owed or promised, and wanted to get back at, get revenge, "do to him what he did to me".)
Essential hypertension	Felt threatened with harm and had to be ready for anything. (Felt in danger, anything could happen at any time from any side; had to be prepared to meet all possible threats, be on guard.)
Migraine	Felt something had to be achieved and then relaxed after the effort. (Had to accomplish something, was driving self, striving, had to get things done, a goal had to be reached; then let down, stopped the driving.)
Multiple sclerosis	Felt he was forced to undertake some kind of physical activity, especially hard work, and wanted not to. (Had to work without help, had to support self and usually others; wanted not to and might or might not express wish for help or support.)
Metabolic oedema	Felt she was carrying a heavy load and wanted somebody else to carry all or part of it. (Had too much on her shoulders, too much responsibility; wanted others to take their share of it.)

ADDITIONAL ATTITUDES

Rheumatoid arthritis	Felt tied down and wanted to get free. (Felt restrained, restricted, confined, and wanted to be able to move around.)
Hives	Felt he was taking a beating and was helpless to do anything about it. (Was being knocked around, hammered on, being mistreated or unfairly treated.)
Acne vulgaris	Felt he was being picked on or at and wanted to be let alone. (Being nagged at.)
Psoriasis	Felt there was a constant gnawing at him and that he had to put up with it. (A steady boring, a constant nagging or irritation or annoyance.)
Nausea and vomiting	Felt something wrong had happened, usually something for which the patient felt responsible, and wished it hadn't happened. (Was sorry it happened, wished he could undo what happened, wished things were the way they were before, wished he hadn't done it.)
Constipation	Felt in a situation from which nothing good could come but kept on with it grimly. (Felt things would never get any better but had to stick with it.)
Raynaud's disease	Wanted to take hostile physical action. (Wanted to hit or strangle, wanted to take action of any kind, had to do something.)
Regional enteritis	Felt had received something harmful and wanted to get rid of it. (Had been given or had received something damaged or inferior, felt he had been poisoned, wanted the situation to be finished, over and done with, disposed of.)
Backache	Wanted to run away. (Wanted to walk out of here, and get out of there.)

Schur (1955), who calls it the 'secondary symbolic elaboration of the symptom'.

Regarding the problem of unconscious cues, the *interview study* design alone cannot completely dispose of the possibility that judges are finding the patient's disease first by unknown means, and then unconsciously choosing the 'right' attitude. The medically unsophisticated judges might have been able to do this, though it seems unlikely, and any replication of the design by those wishing to disprove the hypothesis or even by 'neutral' investigators would also be subject to this same objection.

But there are two other lines of research which do bear on both problems. One eliminates the

judge, with his possible unconscious cues, by putting the judging in the hands of the patient, who is asked to select which of a number of cartoon depictions of attitude statements most nearly resembles his own. The problem is whether he picks the one thought to be associated with his disease or not. Patients do, at significance levels of confidence (Benjamin, 1961). In another line of study the investigators suggested attitudes to *healthy* people under laboratory observation. They found then that the physiological changes observed were in the specific direction of the diseases to which the attitude belongs, and that other attitude suggestions produce opposite changes, also in the direction

of the appropriate disease. This cannot at present be done for all the attitudes because of technical difficulties, but it has been done for some. Thus, Graham and co-workers (1960, 1962a) have shown that the hives, hypertension, and Raynaud's attitudes can be strongly suggested, and that appropriate physiological changes of considerable degree occur. These studies employed careful controls and achieved statistical significance. Still, where this has been done, we do not have a disease; we only have evidence that a psychic stimulus can produce physiological reactions similar to those found in disease. This is familiar ground from studies using hypnosis; (Sarbin (1956) provides innumerable examples). It does dispose of the argument that attitudes merely reflect the altered view of the chronically ill.

This is as far as the research goes at present. The specific and regular association of words with physiological expression seems provisionally established; the unconscious cue problem rather well eliminated, and the existential problem at least partly answered. The obvious 'spread' of the statements indicates that they are not finished products; they will have to be refined, but they are present.

Attitude Statements in Psycho-Analysis

Though published case reports include many communications highly suggestive of attitude statements, the material is rarely verbatim. Schur's (1955) classic eczema case is an example. In speaking of relapses of the skin lesions he reports '(such) a relapse was usually accompanied by stubborn, sulking resistance, by loss of insight and by new doubts in the validity of the analytic approach to an "organic" condition'. A verbatim record of hours preceding an exacerbation would doubtless reveal that the patient said she felt she was being frustrated, blocked, and interfered with, unable to make herself understood—and could do nothing about it except take it out on herself (the eczema attitude). Yet Schur was dealing with highly complex economic and dynamic problems, and concluded that he could not see any 'specificity of personality, of conflict or defence against one phase of sexuality, or of aggression and the defense against it' in his eczema patients.

One reason why the attitude statements seem to have escaped notice by analysts is that analysts work intensively with a few patients; we need to hear a great many people say very similar things to notice them. The technique of free association

does not tend to crystallize them out in so many words, as does a more standard interview. We tend to listen for unconscious or preconscious links behind manifest content, and are not so apt to notice relatively banal conscious stereotypes. If we are looking for Gestalts, symbolism, and primary process mechanisms, we may miss the 'innocent' attitude statements. But they are there, and are quite easy to hear once called to our attention. They may even have led in part to some of our theory—the nausea attitude is related to Freud's formulations (Freud, 1920) concerning the purified pleasure ego; the colitis attitude, and (less obviously) the constipation attitude are straight out of Abraham (1927). The ulcer and hyperthyroid attitudes have a familiar ring (oral revenge and separation anxiety respectively). Other illnesses are rarely seen by an analyst, and if a patient happened to develop metabolic oedema (Gordon and Graham, 1959) or multiple sclerosis, the analyst would not be likely to concern himself with it.

Another methodological problem is the absence of indicators in 'silent' illnesses, such as hypertension. One cannot know when the pressure is elevated and when not. (Attitude: felt threatened with harm and had to be ready.)

A young male patient was wrestling with phallic rivalry problems and on a certain day was preoccupied with some flirting he had done with an older woman. Oedipal problems had an especial poignancy for him for a number of reasons. My silence troubled him. He said 'For God's sake say somep'n—I can't fight in the dark. When you talk I can organize around it and fight. Lemme know where it's comin' from—it's uncertainty that gets me. I feel like before a game or a fight—ready, but it's not like panic.' He had a mild hypertension, and though I suspected this attitude statement would be accompanied by a rise in pressure, I had no proof of it.

At other times the attitudes are directly involved either in the presenting symptom or in resistance and defence problems in the transference, and assume considerable dynamic importance. (Raynaud's disease attitude: wanted to hit back.)

An inhibited soft-spoken man came for treatment of his characterological problems. He had had a mild Raynaud's disease at periods in his life.

In our first hour he was telling me about his

strict father and, as he got into descriptions of childhood beatings, he blocked, became very anxious and tense, and could not proceed. I commented that some feelings belonging to those times must be coming between us—had he ever wanted to defend himself actively—to hit back? A burst of tears brought: 'Yeah—I guess I wanted to hit back all right—I wanted to kill him.'

Sometimes the attitude statements are thus undisguised, sometimes not. (Attitude statement for asthma and vasomotor rhinitis: felt unloved, out in cold, and wanted to shut the person or situation out.)

A young woman came to analysis because of nocturnal panic states. A long-standing loneliness, depression and inhibition had prevented her from committing herself to relationships, goals, and social role. Her delicate beauty and social poise masked her unhappiness effectively in most situations, and one would not have guessed that she had all her childhood been a tomboy. She had suffered severe asthma as a child, which was replaced in late latency by hay fever, but this was no part of her current concern. Mother and father had both been mainly concerned with developing a family business—the mother as a book-keeper, the father as organizer and promoter, and there had been little warmth for the patient from either. An older brother, closer to the mother emotionally, and the sibling for whom the father said he was building the business, was a hated rival all through childhood. As a little girl her closest friend was a beloved dog, whose death she mourned for years. She would retire to her room, weep with the dog when he was alive, or later on weep at his memory, while containing her rage and pain in fantasies worthy of the Arabian Nights tales or Mickey Spillane. In these she was captured, tortured, and raped by a pirate, or was an *ingénue* Mata Hari, and blood-curdling massacres, tortures, and hair-breadth escapes took place daily and nightly. Though she appeared to be a sort of 'Miss American Sorority Girl', her inner volcano began to escape fantasy and to erupt in a sort of *pavor nocturnus* involving fear of a bedroom intruder, under the impact of her first serious love affair.

Her analysis proceeded successfully after a very skittish beginning. She tended to run away with every rise in the transference

temperature. She rarely spoke of her rhinitis, but she invariably made exacerbations obvious by taking a tissue to blow her nose at the beginning of an hour. I learned that such a signal meant that she would be talking of an alienation in her emotional life, usually preceded by a quarrel.

'Well [*blowing her nose*] I went out with B last night and we were going to talk out our problems. So—we did. But he did the same old thing—he just turned around, said it was all his fault—that I was entirely right—makes me feel terrible—we just can't talk to each other. I can't reach him. I want someone I can lean on. We either say we're going to talk about all these things and then we never get around to it because he wants to be with other people or first it's all my fault and then he turns around and says I'm entirely right, that he's no good. I dunno if he means it or not—it makes me mad [*tears*] I feel completely blocked. I don't care if I never see him again. The only thing is for me to get away *completely*. So I went home. K [*brother*] and mother were talking business again [*which continually irritated the patient because she was excluded*]. So I went upstairs to my room. Somebody had left the window open. The room had been picked up. I tend to leave things around and clean up in spurts. Mother came in and said something about cleaning up more often because she wanted to show the home. I just blew up—told her to leave me alone—not to come in the room if it bothered her—all I can think of is getting completely away from this town.'

The material of the hour included a dream in which a boy was rubbing salt in another boy's wounds (which included an arm amputation)—recollections of hypnagogic sensations suggesting masturbatory experiences, earlier amputation dreams (in one, a girl has a breast amputation), rivalry with brother for mother, etc. One could easily miss the asthma—hay fever attitude in attending to dynamically important 'deep' material.

A mild flare-up was preceded by a dream (after a mild quarrel with her lover) in which she was walking about barefoot and alone in the streets in snow. Another was preceded by a restless night again following a quarrel. She drifted in a hypnagogic state for some time after retiring: an atomic attack had been announced, with two hours' grace to prepare; she rushed home and found that her mother

and brother had left without her. Deciding to leave the danger area, she retired to a bomb shelter with a male companion, stayed there a week, emerged with him, and on bicycles proceeded to the family summer home (now occupied by refugees except for a small cabin) where a new life and civilization was begun. 'I just was mad—didn't enjoy the date, though he was nice—and was ready to say the hell with everybody.'

The material of the hour did not contain a more explicit attitude statement, though we can interpret the fantasy as expressing one.

The Theoretical Background

The tendency in the theory of early states of life is to postulate either that they are highly organized or highly disorganized. The Kleinians are in the first group, with their theories of complex fantasies in earliest infantile life—they, Glover (1956) comments dryly, credit the suckling with the mentality of the 4-year-old. The number of useful observations and ideas the Kleinians offer in regard to psychosomatic linkages and mechanisms is limited. Leaving aside such ideas as Garma's (1958) incorporated biting mother image as a cause of ulcer, one member of the group, Wisdom, has made some interesting suggestions (1953, 1959). He proposes that when threatening internal images (he calls them 'ghosts') are projected on the outside world, and when their threats cannot be contained in visual imagery but are experienced kinesthetically, illness results. The body reacts as if it had been injured by a threatening person. Wisdom makes no suggestion concerning the mechanism by which such a regressive movement takes place, or how such a mechanism comes about in the first place.

At the opposite extreme is the 'physiological infantilism' theory of psychosomatic illness of Hendrick (1948, 1953). He originally defined this as 'the tendency to discharge conflict in those organs where the physiological lability of normal immaturity has been retained or can be re-established'. He cited rather scanty evidence for his theory: the poor heat regulation of the premature baby, the greater leucocytic and fever responses to infection in infancy and childhood as compared with later years, the irregularity of the EEG in the first years, and the tendency for children to respond by nausea and vomiting to threats of loss of love (and similar responses) in childhood. The newborn is pictured as being

poorly organized, given to global responses to stimuli, having unstable homeostatic regulation, and responding in an undifferentiated way to stimulation with all available apparatuses. Psycho-analysts find this theory appealing, possibly because the primary psychic process, with freely mobile cathexes, condensation, and so on, 'fits' elegantly with a similarly formless 'primary process' somatic organization.

Between the two extreme possible views of earliest organizations, there are theories of great variety. To mention a few in passing, Felix Deutsch (1953) suggests that patterns are fixed by early illness or injury, so that specific somatic mechanisms become connected with specific psychic constellations. Therese Benedek (1949) has explored specific patterns of mothering and difficulties thereof, as bearing on mechanisms of psychosomatic illness. Gerard (1953) is another who followed similar lines (mother is the first neutralizer of response). Greenacre (1954, 1958) traced the influence of premature stimulation of a sensual nature on psychosomatic mechanisms. Hartmann's (1939) theories emphasize more than many others the biological givens of the primitive ego, their taming and change of function, but he has not been especially interested in psychosomatic illnesses. Grinker's field theory (1954) includes all the factors involved, but Grinker has stressed the need for better understanding of intermediate phases between unorganized states and patterned responses, including precise psychosomatic linkages.

It seems to be true that the more a theorist leans on Hendrick's view the less his theories allow for psychosomatic specificity. There is a certain circularity that seems inescapable. Since the assumed raw somatic response is believed to be unorganized, it can emerge *only* when *organized* ego layers are dissolved, as it were, horizontally in regression. Gitelson (1959) and Schur (1955) are examples; neither accepts specificity. Both produce cogent arguments that the complexities of ego psychology make specificity improbable. As we confront the complexities of individual maturation we tend to push the point of take-off from which we assume that individuals part company with their fellows further and further into formless areas. Schur (1955) has presented evidence that there is in fact a parallel development of the secondary process with the desomatization of anxiety responses: i.e. 'thought-like' (cognitive) neutralized anxiety responses give way in regression to raw somatic and psychic primary process responses to stimuli.

This idea of a complementary series is useful, but again says little regarding specific patterns in the range between the most primitive and most organized responses.

Glover (1956) avoids this dilemma with his concept of ego nuclei, persisting in functional activity through succeeding organizations. Perhaps it is worth recalling his definition of an ego nucleus: an ego nucleus is 'any psychic system which (a) represents a positive libidinal relation to objects or part objects, (b) can discharge reactive tension (that is, aggression and hate against objects), and (c) in one or another of these ways reduces anxiety'. An example is an oral system which gratifies instinct on a part object, the mother's nipple, can exert aggression towards the nipple (in sucking, pulling or biting), and is able to prevent some degree of anxiety. From one year onward, the ego is polynuclear for Glover, organized out of a primary functional phase (the term is his) in which simple discharge of tension occurs. Instead of consecutive horizontal organizations, each succeeding the previous one (oral, anal, phallic) of the early libido theory, Glover stresses a vertical continuity of early mechanisms of discharge throughout all succeeding organizations. No earlier phase goes out of operation entirely ('they have a kind of life of their own') in subsequent phases. For Glover, psychosomatic and delinquent conditions show a wide range of symptoms, ranging from simple discharge phenomena produced by dammed-up instinct to highly organized results of intrapsychic conflict. A vivid example is the existence of very primitive perversions in patients who show no comparable degree of ego disorganization. Note that Glover's theory easily encompasses instances of multiple psychosomatic illness in the same person—a fact difficult for other theories to handle. It seems that Alexander's theories (1950, 1961) approach Glover's, rather than any of the others, in that the specific conflicts postulated involved organized expressions (like a conflict between crying and confidence in a mother image) rather than raw instinct discharge. The drives Alexander *seems* to be talking about are, in other words, less sex and aggression in raw form and more like the expression of drives via ego nuclei or later combinations thereof. This may account for some of the criticisms levelled at Alexander's formulations (Schur, 1955).

We may turn for help in resolving these controversies (especially the crucial structural one) to those who have observed infants directly. The

physiological infantilism model does not bear up well, as their level of organization and homeostatic functioning is quite high except where the types of stimuli are not a part of the normal habitat of the infant (Rubinfine, 1959). In fact, far from finding disorganization, these observers are identifying more organized 'givens' of behaviour, beside the familiar smiling, yawning, and reflex behaviour. Benjamin's (1959) description of differentiated anxiety responses is an example. These appear as innate maturational patterns in the form of 'stranger anxiety' and 'infantile separation anxiety'. Those who have studied early defences via direct observation of infants tend to trace a continuous series beginning with biological prototypes and ending in familiar psychic defences. Escalona (1959) has pointed to Piaget's work on cognitive functions, and his concept of sensorimotor intelligence, as providing a model for understanding other types of function. Just as logical thought is preceded by perception and motor function having little or no psychic representation, later defences may well rest upon earlier schemata of organization of biological functions, which we might call, to continue the parallel, a sort of secret-sensorimotor level of defence. As maturation proceeds these early defences or ego nuclei can be transformed, just as Freud (1915b) postulated in the case of projection. A half-century ago he suggested that this defence and its origin is a biological given—the see-touch-mouth sequence and its reversal in spitting out—which is later 'tamed' into a psychic mechanism. Freud also repeatedly emphasized the role of motor behaviour in establishing body boundaries; what is external can be made to disappear, what is internal cannot (1915a, 1930).

The Attitudes in Relation to Theory

The forms in which attitudes appear have been shown to vary, from explicit statements, as in the interview studies, to disguised expression in preconscious fantasy and dreams. Examination of the *content* must include two additional facts which are latent in the material presented thus far. The first fact is the passive immobility of the patients: they do not run away, but remain in the situations which distress them. The counterforce against running in some fashion is usually silent (this point is under study) but the hints we have thus far suggest positive libidinal or dependent strivings as the other part of the ambivalence, as the reported case material shows ('I want someone to lean one'). The second

fact may not need spelling out, but is easily documented in case material: no actual injury has occurred.

We have to explain how the body is reacting, what it is reacting to, and how the specific words involved in the perception matter. The physiological parts of the attitude make use of various motor, secretory, vascular, and endocrine apparatuses which are biological givens, and which need individual discussion. The general pattern of reaction appears to mitigate, avoid, or repair an injury which does not occur in fact in the external world. In most instances the reaction puts distance, or a barrier, between the inner self and the world. We can infer that the injury expected or experienced occurs intra-psychically, but is projected into the environment, on to persons and situations. The words used are not any longer figures of speech, but have been treated literally, along primary process lines—a 'replacement of external by psychical reality . . . (characteristic of) . . . the system Ucs' (Freud, 1915b). Cognitive secondary process reactions have given way to resomatized responses, signal affect and anxiety to primitive precursors of defence. The path has been backward from logical through sensorimotor and 'secretor-sensorimotor' responses. We have taken account now of Schur's, Wisdom's, and Escalona's models.

The specific words and specific mechanisms are linked in the curious literal way Freud described as occurring in schizophrenia (1915b). He pointed to the tendency to treat a word as if it were a pun, the second meaning of which is a motor expression. His patient Emma N complained that her eyes were twisted, that her lover was an 'Augenverdreher' (which means 'deceiver' as well as 'eye-twister'—also one who 'catches one's eye'). A schizophrenic girl told me why she bumped herself along the corridor wall: voices told her she ought to be 'bumped off'. A schizophrenic man who came to the hospital because of aerophagia told me he was belching in order to get rid of an offensive hallucinatory phallus and semen which voices accused him of sucking. In the light of Piaget's work (Wolff, 1960) it may simply be that schizophrenics have regressed along normal paths of development and are once more expressing the first verbal phases of sensorimotor intelligence. Even in normal persons there are many persistent expressions of sensorimotor intelligence in daily life. We need only recall the writer who assists his fingers with an agile tongue, the mother who

takes an automatic bite with every spoonful she feeds to her babe, or the determined wielder of shears who cuts away with his jaws.

In the attitudes we see a similar mechanism: the body acts as if the words 'I'm taking a beating' had a literal meaning. Glover's formulations concerning the persistence of primitive discharge patterns in otherwise well-organized personalities (the persistent life of ego nuclei) help us understand this. So do Wisdom's suggestions: if one wants to destroy a threatening 'ghost' (image), and if this destructive impulse is projected and assigned to some person in the world, one has no way of discriminating whether he is in fact going to administer a beating or not, and one's bodily defences prepare for all eventualities. The projective mode of the attitudes, in short, interferes with reality testing. Meanwhile one may say in words that one is expecting a beating without losing all reason.

Taking hives as a paradigm, then, I can summarize the argument in this way: the individual is caught in an ambivalent conflict, and remains in it because of positive libidinal needs, while projecting on outside objects the aggressive component of the ambivalence. He then mobilizes primitive apparatuses to mitigate the danger of injury or to repair injuries inflicted. As stress waxes and wanes, rational verbal responses give way to more and more primitive somatic responses, which can reverse as pressure lessens. The persistence of a verbal linkage is evidence of the continuum along which these movements occur and, further, of the projective nature of the primitive defence. All the skin disease attitudes follow this model easily. The colitis, ileitis, and nausea-and-vomiting attitudes are all clearly projective in mode, though from different zones. The asthma attitude statement involves 'getting rid of', though Fenichel (1945) has interpreted the dynamics of this illness to be a blocking of respiratory incorporation.

Other primitive defence precursors seem more prominent in the other attitudes. Hyperthyroidism has an attitude statement that sounds like pure separation anxiety; the hypertensive attitude statement suggests stranger anxiety. We have been investigating the possibility that each is associated with a specific catecholamine (adrenalin and noradrenalin respectively). Both correspond to the earliest primary functional phase of Glover, or perhaps the first differentiation of discharge therein. The constipation attitude is in the familiar retentive mode. Backache involves sustained muscular tension

replacing a running away—as though the ‘spitting out’ flight from unpleasure of primitive projection were replaced by a larval running away. If spitting out is later tamed, as Freud thought, into psychic projection, muscular flight (as expressed in the symptom of backache) might well be the prototype of the other form of running away which Freud (1915a) suggested was involved in repression. Perhaps we may be able to detect many *different textures of psychic defences which preserve some hint of their early prototypes.*

Some diseases included in the research remain obscure. We know little of the pathophysiology of metabolic oedema or multiple sclerosis. The former, also known as ‘idiopathic oedema of females’, is closely associated with pregnancy fantasies and pseudocyesis—a curious empirical finding (Gordon and Graham, 1959). The Raynaud’s disease and migraine attitudes appear to have some family connexion with hypertension in that all involve the vascular apparatus, and all have themes which involve preparation or protection against blood loss from injury.

The ulcer attitude involves deprivation and revenge. Graham (personal communication) suggests that the stomach of the ulcer patient is behaving as if a healthy bite of the offender’s soma has been swallowed—an interpretation not entirely incompatible with Garma’s. As a homely example of the desomatization and resomatization of this type of response I will cite one which occurred in my family: while I was on the telephone, a 2-year-old insisted on dialling the numbers in spite of efforts to distract him. At a certain point of frustration, he bit my hand. A 6-year-old brother came to the door, but was satisfied with a verbal request to wait to talk to me. An 18-year-old brother came in, took in the situation at a glance, and though interested in discussion went upstairs to study without a pause. In hand-to-hand combat these refinements are reversed. The ulcer attitude suggests an unconscious fantasy that the bite has taken place, that the enemy has been incorporated.

The Implications of Attitudes for Theory

We have suggested that the attitudes may show ways to trace sequences and textures of early defences into their psychic counterparts and may even shed light on the order in which defences appear. To begin with, the inclusion of so many diseases and so many apparatuses in this viewpoint presupposes a spectrum of biological givens, varying from person to person

in their thresholds of usage. This may be as demonstrable as the thresholds for gastric secretion Mirsky (1958) has studied. This is in accord with the fact of multiple psychosomatic illness. It is in accord with Alexander’s (1955) specificity theories and all others which postulate an *x* factor (or ‘organ vulnerability’ (Deutsch, 1953), or ‘readiness for organ response’ (Schur, 1955), to account for specificity.

Projection is obvious, in many of the attitude statements, on simple inspection. Freud’s (1930) formulations regarding the purified pleasure ego make it clear that he considered projection the basic defence. Anything unpleasurable is assigned to the outer world so that it may be avoided if possible, along with other noxious stimuli. ‘At the very beginning, it seems, the external world, objects, and what is hated are identical’ (1915a). Freud postulated an earlier origin for projection than for introjection, which at first seems its reciprocal. Glover (1956) believes that for a considerable period of infantile life projection, introjection, and regression are the only defences. Repression, for example, although it also follows the idea of flight from danger, is a comparatively late defence, presupposing considerable organization. While the concept of projection is blurred by multiple definitions of the term and later distinctions such as Jacobson (1954) and Weiss (1947) have made concerning externalization, true projection, and similar differentiations, projection in Freud’s sense involves the basic cleavage between what is self and what is non-self—what is inside and what is outside. Only regression is accorded an earlier origin by Glover, yet we can argue that regression implies an organization from which to *regress*, which is provided by the basic defence of boundary formation via projection.

Freud connected projection with his concept of the Reizschutz in *Beyond the Pleasure Principle* (1920). He suggested that projection arises in an attempt to externalize any internal excitations which produce too great an increase in unpleasure, in order that it may be possible to bring the Reizschutz into operation as a means of defence against them. This concept crops up regularly in discussions of early defences, but a critical analysis of its meaning is beyond the scope of our discussion. It is a construct—a hypothetical model of psychic structure. Rapaport (1951a) proposed that it might have some relation to thresholds and various somatic apparatuses of the early ego. The ebb and flow of the attitudes indicate a hierarchy of levels of

defence in the nervous system like the somaticist's model of levels of abstraction: psychic constructs such as the Reizschutz and counter-cathexis have their origin in, and develop from, somatic givens like the weals of hives, or in the projection of vomiting.

For such primitive defence precursors as this we suggest tentatively a separate category. While related to ego nuclei, and to later affects and anxiety equivalents, they have a special primitivity and direction which link them together. They could be called 'mantle defences', suggesting an integument and their relation to the concept Reizschutz. They function like a magic cloak, put on in perilous situations. Their relation to *superego* nuclei, while fascinating, would take us too far afield. This will be dealt with separately. Freud (1926) said (in *Inhibitions*,

Symptoms and Anxiety) 'I think it is probable that there are some defensive processes which can truly be likened to an attempt at flight, while in others the ego takes a much more active line of self-protection and initiates vigorous counter-measures.' Perhaps the roots of these measures are to be found in mantle defences.

Summary

Autonomous defence precursors, rooted in the biological mechanisms of the undifferentiated ego, specifically related to psychosomatic illnesses, and elaborated in development into desomatized secondary-process verbalized responses, are described.

Evidence for their existence is presented, with the theoretical background which relates to them. The class name 'mantle defences' is proposed.

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SOMATIC SYMPTOMS AND THE TRANSFERENCE NEUROSIS

By

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The transference neurosis, a crucial and characteristic aspect of psycho-analytic therapy, is also its most valuable research tool. Research in the field of psychosomatic medicine has taken many forms, but it is now obvious, as many have pointed out, that a psycho-analytic relationship provides a meaningful frame of reference for the understanding of somatic as well as of other processes.

Schur (1955) came to a variety of conclusions concerning somatization which he was able to fit into the theory of metapsychology. He was able to detect certain characteristics which he considered significant for the patient who might develop a 'psychosomatic disorder'. In the cases he studied, dermatoses, he found a prevalence of narcissistic and pregenital elements associated with widespread impairment of ego function. His patient's object relationships were tenuous and characterized by extreme ambivalence. He thought these cases could be called 'borderline states' and discussed somatization in terms of ego functions. He described a parallel between a prevalence of primary process thinking, the failure of neutralization, and the resomatization of reactions. He referred to an undifferentiated 'psychosomatic' phase of development, a concept similar to Hartmann's (1939) undifferentiated stage of id-ego development.

I would like to extend some of these concepts outlined by Schur without necessarily dealing with those of neutralization or undifferentiated id-ego mass. However, an attempt to understand a somatic process that has been studied from a psychological frame of reference and in terms of its relationships to a variety of defences and other ego functions will also be made here. Regressive phenomena that so frequently seem to accompany the various diseases that have been studied from a psychosomatic viewpoint have been referred to by many authors, and their

significance discussed from a variety of viewpoints. Greenacre (1945) and Bergmann and Escalona (1949) speak of a predisposition to anxiety and to regressive types of anxiety as contributing determinants to the choice of the reacting organ system. Margolin (1953) refers to a physiological regression, whereas Grinker (1953) thinks in terms of the overloading of different ego systems leading to a disturbance in synthesis. Menninger (1954) also focuses on disruption of homeostatic regulatory ego functions under stress resulting in disturbed somatic responses.

These theoretical formulations can be reconstructed in the clinical setting. I would like to expand upon certain aspects of ego adaptation that are related to homeostasis and include somatic systems. In a previous paper (1959) I was impressed by some patients who had two or three somatic disorders that have been psychosomatically considered. I reached certain conclusions about the significance of the disease process from a psycho-economic viewpoint. Here I would like to discuss a case with special emphasis on the transference neurosis, since it served to highlight the significance of the organic illnesses. The changes in the physical condition could be directly correlated with changes in the transference neurosis. The various ego states accompanying each illness have been described in another communication. I feel that a more detailed study of the transference aspects of one patient will enable us to make some formulations regarding ego development with special reference to regulatory factors. This may add to our understanding of the relevance of object relationships, defences, and other integrating features to homeostasis and somatic disturbances.

The patient, a 37-year-old married woman, sought analysis because of free floating anxiety and a variety of obsessional ruminations which

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included thoughts of knifing her children, aged 12 and 15. In earlier years, similar feelings had been directed towards her mother and her only sibling, a nine years younger sister.

Her recognition of a need for analysis was precipitated when she could no longer deny her husband's infidelity or the fact that her daughter was becoming a woman, as evidenced by the daughter's popularity with boys and her father.

The patient had been her father's favourite for the first nine years of her life. With the sister's birth, however, he started giving his attention exclusively to the new baby and turned away completely from the patient. She then found herself clinging to the mother, but considered her a poor substitute, as she was a nagging, complaining woman with a 'martyr-like demeanour'. The patient then became withdrawn, shy, and submissive, and felt herself to be a frightened, insecure, and inadequate person.

Analysis revealed similarities between the current situation and that of childhood. Her husband travelled a good deal because of his business, was never particularly attentive to her, and was sexually passive and withdrawn. He was fairly discreet in concealing his numerous affairs from her but, as is usually the case, furnished her with some clues if she chose to pursue them. He began behaving seductively towards their daughter when she began to acquire secondary sexual characteristics. At this point, the patient's earlier competitive feelings with her sister were reawakened and the repressed rage associated with the helpless feeling of being abandoned and rejected became more intense. She was able to handle angry feelings with a variety of obsessive-compulsive defences, and at the time of beginning treatment was unable to recall or admit any conscious feelings of anger. Even though her thoughts were unmistakably destructive, they were 'only thoughts', completely devoid of any affect.

Since the age of 15, her late onset of puberty, she had experienced typical migraine headaches which consisted of episodes of pounding, 'explosive', left, hemicranial pain, gradually increasing in intensity over a period of one and a half to two days, reaching a peak and lasting for another day, and leaving her in a state of prostration and utter exhaustion. In a typical fashion, these symptoms were ushered in by visual scotoma and were accom-

panied by nausea and sometimes vomiting. The fact that her daughter had now reached the age at which she developed these symptoms was striking. The patient spontaneously remarked that the daughter did not develop migraine and betrayed resentment over the fact that she 'had to suffer' and her daughter could enjoy the frivolities of adolescence.

The development of the transference was especially interesting since various phases were accompanied by specific somatic changes. Her early associations contained a seemingly endless preoccupation with feelings of inadequacy and guilt over the content of her obsessional ruminations. Her behaviour in the analysis was like her mother's nagging and complaining. In spite of this highly-charged material, she never showed anger directly, but always presented herself as much abused (especially because of her husband's indifferent and caustic behaviour) and as one who was constantly taken advantage of by her demanding family. She categorically denied ever experiencing anger. On the contrary, she saw herself as a docile, submissive person who could not understand why others, particularly her husband, ever felt anger towards her.

The dream material, however, revealed manifest content such as war, death and destruction, 'atomic bomb explosions and other cataclysmic events, clearly pointing out the underlying instinctual state. When she had a dream involving only a minimum of secondary elaboration, one usually stimulated by a fairly active interpretation of defences against hostile impulses, she would awaken with a migraine headache. Up to this time, she had not yet been able to feel angry. Towards the end of the first year of analysis, the patient began to experience difficulty in maintaining her usual controls and in being able to feel herself the master of her emotions. She gradually became aware of angry feelings towards me, but did her best to suppress them. Whenever I made an interpretation of her death wishes as directed towards me, she became extremely anxious. As is so often the case, her associations would produce material that indicated a recognition of similar feelings towards her husband and oldest daughter, helping her to avoid the intense feeling that she was currently experiencing. It became apparent that she was struggling desperately against expressing what she considered to be dangerous quantities of rage. She believed

that she was capable of murder and that if she lost control, she would 'blow up' or 'fall apart'.

The dreams were nightmares, and the underlying state was one of panic. As Schur (1958) has described, there is a complementary series of anxiety responses whose understanding is indispensable to formulations about the somatization process. This patient's rage represented an affective response to a panicky fear of dissolution which was associated with intense frustrations at various levels of psychosexual development.

She complained that I was not sufficiently interested in her because I was unable to recognize the intensity of her need to be taken care of. She became jealous of other patients and showed the usual manifestations of pregenitally oriented feelings of rejection and sibling rivalry. The transference neurosis made it possible to make genetic reconstructions. Her mother was recalled as a withholding, ungiving woman who manipulated others by 'parasitically devouring'. She used the defence of isolation to deal with such a denying and controlling mother. She also sought protection and security from the father and cast him in the role of a 'saviour', requiring an omnipotent object to fulfil this role, and the father, because of narcissistic needs of his own, was glad to play the part. When he turned his attention to the newborn sister, she felt betrayed and once again as if she were going to 'fall apart'.

The transference neurosis reflected all these disturbances, and she relived these frustrations in a very dramatic fashion. Anger was being consciously experienced, but expressed very cautiously and in limited amounts. She became helpless and displayed the traits of a panicky infant. She would cry out, 'Please help me, please help me. I beg you to help me. I'm eating myself up.' The signs of ego disintegration were general, and she was unable to carry on simple tasks such as cooking, shopping, driving the car, etc. She felt isolated, desolate, lonely, and abandoned. Even though she seemed to be asking for help directly, the material was by no means object-verbalized. Her movements on the couch, of a random variety and never specifically focused toward the analyst. Even when she was pleading with the words, 'Please help me', she did not seem to be talking to anyone in

particular. I frequently questioned her about this point and she often acted as if she did not hear me or as though she was hardly aware of the fact that I was present.

From a somatic viewpoint, she reported the striking feature that the migraine had disappeared. After having been continually present for over twenty years, it cleared up completely and has not returned (five years have now elapsed). This patient, as one might expect, had always been plagued with the thought of dying and was very much concerned with her physical state. Consequently, she had frequent check-ups with her family physician, who ascertained that her blood-pressure rose from a normal level to a hypertensive one, 180/100, in a period of three months. This period coincided with the above-described transference state, and at least a temporal correlation can be made.

One might characterize the patient's reactions in the analysis as being dissociated ones. She reported several dreams which reflected her disturbed equilibrium and her longings and needs for nurturing. The manifest content consisted of houses crumbling around her, falling off boats and drowning, and falling through empty space. There were certain erotic components present, but what is most relevant to the present thesis is the fact that when the analyst was represented, he was usually in the background and at a very great distance from the patient. As previously stated, this was reflected in her behaviour also, and she often spoke of the analyst as being in another world or another frame of reference, one that she could not get to or even comprehend. This orientation, or rather lack of orientation, was reflected in all other object relations as well.

Although the dream material represented the object relationship of the transference in terms of distance or lack of relatedness, her behaviour and associations pointed out the complex aggregate of functions that belong to objects by stressing her needs and her inability to achieve gratification. The subtle contribution of the object to structure formation which is accompanied by efficient secondary process integrative techniques for drive satisfaction was also emphasized by its absence. Previous disappointments and the specific aspects of her relationship to the mother made the patient fearful of being engulfed by and helplessly vulnerable to the infantile imago of

the devouring mother and resulted in a general withdrawal.

Slowly, the ego once again achieved synthesis and integration. After about six months of the turmoil described, she once again felt able to handle the expression of feelings, believing herself competent and, although still aware of immense quantities of anger, no longer feared that she would 'let loose'. Although she was able to have superficial object relationships, none of these contained any real feeling or warmth. They were patterned exclusively along intellectual lines.

Again, the evidence for this conclusion came from the study of the transference neurosis, or rather the defence against the transference. When the analyst was not conceived as a person or responded to with affect, she was able to be pleasant and to communicate on a sophisticated and intellectual level. In dreams the analyst was represented as being somewhere off in the distance or hidden behind a cloud. Previously, when she showed an intense degree of disintegration, and had similar dreams, she seemed to want to reach out towards me in a clinging, helpless fashion, but could not permit herself to do so. Now she did not seem to have a need for an object except to demonstrate the success of an omnipotent controlling orientation.

This defensive state was characterized by obsessive compulsive techniques similar to the personality organization noted when she entered analysis. Both sexual and pregenital elements were responsible for such an orientation and were further elaborated, indirectly of course, in terms of her relationship to her mother.

If she could control and magically manipulate objects she could feel safe. Her underlying state was precarious, one that could easily be flooded by uncontrolled anxiety. When able to achieve equilibrium she used anal defences which served to protect her both from a denying and devouring mother and later from a disappointing father and now from the analyst. Oedipal as well as oral frustrations were involved and had to be denied by an isolation from objects as well as repression of affect.

Physiologically her condition became worse. Her internist reported increased hypertension, usually 220/120, and sometimes higher in spite of medication. Ophthalmological examina-

tions revealed the beginning of a hypertensive retinopathy.

As in any analysis, there was a back and forth movement from one particular organization to another, dependent on many variables, not the least being the frustrations and gratifications of the transference neurosis. She returned to this well developed obsessive compulsive state at least four separate times, and exhibited some transient obsessional defences on other occasions also. The internist towards whom she related in a less intensive, though parallel, fashion than she did towards the analyst always found severe hypertension at such times. Reiser (personal communication) has raised the question whether her increased blood-pressure may have represented a 'transference reaction to the internist'. Undoubtedly her relationship there, too, was founded upon the projection of infantile imagos, but during the states of helplessness which alternated with the obsessive compulsive state he found her blood-pressure to be lower and even normal, so that a consistent correlation could be made in terms of what he found when he took the blood-pressure and the ego state.

To summarize, these striking temporal correlations could be made: (1) when her behaviour was disorganized and without the ability to relate to the analyst, she suffered from hypertension; (2) when her behaviour was organized but her relationship to the analyst was a distant intellectual one, she had an even more severe hypertension; and (3), when she was able to experience feelings, even though disruptive ones, towards the analyst, her blood-pressure returned to normal.

From a phenomenological viewpoint, the latter regressed state was very similar to the first state of regression when the hypertension was discovered. The differences, however, are significant for understanding the relationship between the ego state and the clinical somatic state.

First, the recognition of the existence of anger and a need for a target which became part of the transference relationship also enabled the patient to recognize the existence of objects in an affective fashion. In the first state of ego regression and panic, she felt herself at a great distance from others, finding herself unable to relate to them except in a tangential way. In the well-defended obsessive-compulsive state, she related to

objects mainly in an intellectual way. Now she recognized them as being instrumental to her rage, which meant that she was able to detect their frustrating (but also gratifying) potential.

As the analyst became a more significant figure in her life, she was able to experience dependent affectionate longings as well as anger. All analysts have at one time or another experienced the rather remarkable and dramatic changes that occur when the patient who is withdrawn or who rigidly holds himself back from forming a relationship is finally able to tolerate affect towards the analyst. Distrust and negative feelings regularly accompany libidinal expression under these circumstances, since the affects are derived from infantile imagos. One has the opportunity to observe a variety of primitive mechanisms in this state, and in contrast to the previously constricted, withdrawn, apparently objectless state, correlations between the somatic and the rapidly shifting emotional reactions are more readily discerned.

Discussion

The observations of behavioural integration and breakdown in this patient become meaningful if considered in terms of the capacity for object relations during various ego states. The archaic and infantile object relationships are the axis around which the transference neurosis revolves. The existence of a somatic dysfunction could then be correlated with the variables of the developmental position of the ego and the intensity of affect in object relationships as well as their quality in terms of psychosexual development.

The superficial adjustment of the patient was not a true indicator of her total psychic and somatic integration. In the rigidly defended state she was unable to participate in affective experiences and her way of relating to the outside world was cold, sterile, and intellectual. The transference neurosis was characterized by a lack of object involvement. Her somatic symptoms were intense in spite of a good surface adjustment. The helpless, desperate states where she was making demands of megalomaniac, omnipotent proportions and her operational energies were primary process in nature and were also accompanied by somatic dysfunctions. The physical illness disappeared concurrently with her ability to relate to the therapist and recognize him in a more structured fashion. True, she was

still helpless and desperate, but the transference state was markedly different. Somatic signs were absent, even though on the surface there seemed to be some phenomenological similarities to the periods of helplessness that were accompanied by hypertension.

I feel that the manifestations of the transference neurosis of this case indicate relevant correlations between object relations and the appearance of the somatic symptom. The following hypothesis emerges if we generalize from these observations: an ego state that is sufficiently structured to be able to maintain cathexis of a meaningful object relationship, although this may not be phenomenologically apparent, is not found in conjunction with certain signs and symptoms that have been considered from a psychosomatic viewpoint. This relates once again to the thesis that somatization is more consistently correlated with a primary process than a secondary process oriented ego.

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We presume that the earliest perceptions of the neonate are bodily sensations without ideational components. The responses observed are massive and global in nature, involving motor discharges as well as vasomotor and other autonomic phenomena.

Many have suggested that the first representation of the outside world is the breast (or other source of nourishment) experienced as a part object. Later a variety of part objects become integrated into a whole object. The latter is not just a sum of the various part objects but constitutes a new gestalt, one that transcends the somatic nature of the part object, and begins to involve elements of a more structured nature, including the psychological or mental.

The sensory registrants of the neonate are impressed on the diffusely and primitively organized ego where the qualities of mentation and consciousness are still embryonic. As external experiences impinge on the maturing organism, higher perceptual centres are established which lead to the development and differentiation of all the sensory modalities as well as to consciousness. Herrick (1956) describes many experiments demonstrating that the development of sensory functions, such as the visual, depends on transactions with the outer world. Without appropriate external stimuli, neurophysiological maturation is defective and the perceptual function fails to develop. The corresponding development of the executive

apparatus is even more obviously dependent upon gratifying object relationships and the incorporation of satisfactory experiences.

What has been postulated for sensory impressions is a hierarchy (isolated sensations and part objects, to gestalts and whole objects), and the executive systems can be considered in a similar fashion. From a developmental viewpoint, we can conceive of a continuum from the involuntary nervous system whose responses are unlearned to primitive, reflexive levels of the voluntary nervous system, and finally, to deliberate reality-attuned, planned alloplastic behaviour.

When the ego adjustments undergo regression, we usually note the return to a primitive state, at least relatively speaking, which involves all ego systems, sensory, motor, and integrative. With the advent of primitive needs, we often note a lack of integration and in extreme cases a state of disintegration which may be accompanied by panic. The ego attempts to re-establish a balance which is oriented more along the lines of the primary process than previously and includes more autoplasic and vegetative responses. In terms of a continuum we note a regression from secondary process structured needs and responses, which include object relationships, to both affective and somatic dysfunctions.

Jacobson (1954) gave a detailed description of the primitive phases of development and the shift of energies in regression as they underwent a process of 'defusion'. Freud (1923) had discussed this point in terms of his structural hypothesis and libido theory, emphasizing that the ego is flooded with destructive, aggressive forces as it regresses. The preponderance of destructive energies over libidinal occurs in an unstructured state where the organization and synthesis of the ego is disrupted. Freud (1920) feels that in states of greater organization, such as a multicellular in contrast to a unicellular one, there is a neutralization of the death instinct and the diversion of destructive impulses towards the outer world.

Without becoming involved in questions of instinct theory, we can emphasize that in regression there is a loss of functional unity and the various ego systems, both sensory and executive, operate in an asynchronous fashion.

In regressed states, higher order gratifications from object relationships are not attained, a circumstance that adds to frustration and rage. In turn, the behaviour becomes less efficient; e.g. purposeless kicking and the screaming of a

tantrum are less efficient than suckling, the autonomic responses being integrated in the latter and not in the former. The unintegrated visceral systems that accompany the tension, rage, and frustration are likely to lead to the formation of somatic symptoms. In the decompensated, regressed state, the unity and synthesis that is characteristic of the secondary process breaks down and the types of responses and gratifications become characteristic of a more primitive developmental level and less effective.

The techniques that the ego has at its disposal in dealing with its needs have been acquired through a variety of gratifying and structuralizing experiences which have become introjected. These functional introjects include the objects that have made gratification and mastery possible. In the regressed relatively objectless state such integrating experiences are not available and the disruption of various ego systems may be associated with visceral symptomatology as previously described. The object is being considered from an operational viewpoint and need not be separated from its functional significance in terms of gratification of drive needs and structuralization and synthesis.

The case, I believe, highlights some of these mechanisms, although it should be emphasized that the psycho-analytic material does not give us any evidence to determine why a particular organ system has been involved; e.g. the disappearance of the migraine and appearance of hypertension cannot be explained by the psycho-analytic data. We can focus upon the particular ego mechanisms operating at the time of the somatic dysfunction. Interesting comparisons between particular traumas and organ neuroses can be made, although we should be cautious in drawing any conclusions regarding causal connexions between these two sets of data.

This case material reveals the intimate involvement between somatic dysfunctions and states of psychic equilibrium. In view of the varied ego states observed in the transference neurosis, it will be difficult to make any one-to-one correlation here between the state of psychic integration and the somatic symptoms. The varied phenomena of reality-adjusted behaviour and what at other times seem to be states of ego disintegration do not consistently correlate with the presence or absence of a somatic syndrome. Consequently, it would be difficult to view the somatic symptoms as part of a specific ego defence or instinctual tension as Schwartz and Semrad (1951) and Saul (1939) have done.

Alexander (1950) has frequently written about the lack of symbolic significance of the symptoms of an organ neurosis, and here, too, I am considering the physical phenomena as being manifestations of physiological pathology, not having achieved any mental representation.

During regressed phases, when hypertension was present, the drive needs were not organized in a secondary process fashion and did not have psychological characteristics such as imagery, thought, or some element of conceptualization and abstraction. The ego operations were somatically and viscerally oriented.

The study of regression leads one to a formulation of a hierarchy of needs and of responses which gratify these needs. The object relationship is a factor in the maturation and development of drives and ego structure as well as a result of such structuralization. With the acquisition of efficient responses the drive needs also become more sophisticated, enabling the ego to relate at more highly organized reality levels which again include objects. In regression there is an ego disruption which affects object relations also, which in turn may lead to a further disruption and regression of ego functions.

What can be correlated with the somatic syndrome in this case is the presence or absence of an object from whom gratification is sought, as was observed in the transference neurosis. This patient demonstrates that as long as she hoped or expected to have her needs met in an object-directed and more or less reality-attuned fashion, she was free of somatic ailments. When she withdrew from objects or regressed to such primitive modes as viewing objects only in terms of magical omnipotent qualities, her somatic symptoms reached their greatest intensity.

The frustrated id impulses included both pregenital and oedipal elements. Both the wish to possess the analyst exclusively during the father transference and the need to receive dependent care and nurturing were apparent when she was able to relate in an object-directed fashion. Still, she had often to retreat from this position because she felt it was inevitable that she would be disappointed, as occurred with her father when he turned to the younger sister.

Her anal defences served to protect her from such a disappointment as well as to erect a protective barrier from what she later revealed was the fear of a maternal assault. During her obsessive-compulsive adjustment, she was able to conceptualize an object but not to seek

gratification from it. She withdrew from an affective relationship and maintained omnipotent control by using the defence of isolation. If she relaxed this control, as she had done earlier in the analysis, she would be faced with the catastrophe of feeling engulfed by an all-powerful, destructive mother imago. These mechanisms were clearly indicated during the regressed state that was accompanied by hypertension.

When the patient's behaviour was disorganized and indicated a state of ego disintegration, her capacity for object relations was inadequate for a variety of reasons. When she withdrew in a helpless, panicky fashion, although it was so obvious that she needed a sustaining relationship, it became apparent that the perceptual, synthetic, and executive ego mechanisms responsible for transactions with an external object had become inoperative as they were flooded with rage. Her behaviour and associations seemed to indicate that she had erected a wall between herself and the analyst and then she would 'beat her head against the wall' to find a measure of sustenance. Without the object to save her, she felt she would be devoured by her rage, but then she felt she would also devour the object.

The later stage of regression in treatment was not accompanied by hypertension and showed different mechanisms of relating to objects. Her capacity to seek from an object was different. Now she could reach out and cling in an anaclitic fashion. The object was able to counteract her destructive rage as her father had been able to do in childhood. This transference reaction was a synthesizing force. Furthermore, she was able to externalize her hostility and direct it towards the analyst, and this process also had an equilibratory effect. This type of object relationship was a primitive one, but still she was able to utilize it in the interest of maintaining an equilibrium, even if it was an infantile one and manifested by behavioural disorganization.

One other aspect of the patient's reactions will be commented upon. It was noted that a good deal of this woman's struggle concerned the repression of angry impulses. In this instance, her anger is considered as representing a sign of the disrupted ego which was reflected in both the psychic and visceral systems. Its origin certainly would include the frustrations and vicissitudes of her early psychosexual development and included reactions to penis envy, oral frustration, etc. The effects of the anger on the psyche cannot be separated from the frustration of the drive needs that caused it. So once again the

patient's position vis-à-vis objects remains an important axis.

Summary

This clinical study uses the frame of reference of the transference neurosis in order to determine what role object relations have for the satisfaction of drive needs and the total psychic integration of a patient who suffered from two somatic syndromes, migraine and hypertension.

Drive needs and object relations are conceptualized along a continuum, a hierarchy whose spectrum extends from primitive omnipotent megalomaniac, primary process modes of operation to judgemental reality-tested sensory and motor phenomena that are organized in a secondary process fashion. The somatically oriented drive needs in a primitively fixated or deeply regressed ego do not have a mental representation, since the qualities of mentation and consciousness relative to such basic needs are still embryonic. At the other end of the spectrum, the drive is experienced as a conscious impulse that can potentially be gratified in an object-directed fashion.

The study of the transference neurosis of this patient revealed the following striking correlations. When she was able to relate in a non-

autistic way towards the analyst, which, of course, reflected her general status of object-relatedness, she did not suffer from somatic illness. When she was unable to relate affectively to an object which was also reflected in the transference neuroses and which was indicative of a regressed primary process oriented ego state, she suffered from somatic signs.

Here the organ dysfunction is considered as an indicator of a disturbed psychic equilibrium. Any physical illness is the outcome of some disturbance of homeostasis and in turn contributes further to disequilibrium. When the ego was able to handle its needs at a reality oriented object-directed level, then the function of the lower visceral systems was not disturbed. From a phenomenological viewpoint, the correlation between the surface adjustment and somatic illness was not consistently maintained; there were times when the patient seemed well adjusted and the hypertension had reached dangerous levels, and times when she seemed to be in a state of almost complete dissolution and would be practically free of cardiovascular signs. The subtleties of the transference neurosis, however, revealed aspects of her psychic integration which did correlate consistently with the somatic states.

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IMPEDIMENTS OF SPEECH: A SPECIAL PSYCHOSOMATIC INSTANCE¹

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A glance through the psycho-analytic literature reveals that little of it is devoted to the common psychogenic disabilities known as 'impediments of speech'. Nevertheless, thanks to Glauber's (1958) researches into Freud's writings, we find that these have contributed far more to this topic than would otherwise have been realized. For example, not only did Freud define the cause, in the case of Frau Emmy, of her 'capercaillie-like noises' and her disintegrations of phonation, as being of the nature of a tic, but he further stated that stuttering represented 'the putting into operation of antithetic ideas'. My present findings, although confirmatory of both of these discoveries, will, however, be seen to differ in the mode of their approach as well as in their therapeutic implementation. In any event, Freud's conclusions were derived from his work with adult patients, whereas this communication relies on observations on children, in many of whom the condition was still recent and, therefore, not yet progressively 'fortified'.

Among Glauber's own contributions to the aetiology of stuttering, it is of interest that he places special emphasis on the role of the mother, as is confirmed by some of my case material. Coriat, another among the few analysts (see also Gerard, 1947, for instance) who have made this topic their special concern, mainly concluded that speech impediments represented both fixations and symbolizations of the infantile act of suckling. In view, however, of the operationally detailed descriptions which will here be given of some 'impediments', it is worth noting that these three analytic writers, as well as others, would seem satisfied to subsume these commoner psychogenic disturbances of

speech under the general term 'stuttering'. It may be of interest, therefore, to state that my differentiation of 'impediments' and their many varieties was derived from direct observation, in the course of the prolonged analytic treatment of a child case. Furthermore, this case has helped to teach me how important it is not only to differentiate between the types of impediment according to operational cause, but also to determine their multiplicity or the complexity of any one of them. This is not merely a question of the observer's exercising his capacity to distinguish between one type of aberrant phonatory production and another but, as will become apparent, it is therapeutically important to see, or else to be able to deduce, the actual *muscular mechanisms* by which speech impediments are created. This is not in order to institute so-called 'corrective actions', but the opposite. In that these muscular mechanisms, or rather, their inception, especially insofar as these concern the tongue, are here regarded as the psychosomatic expression of affective states, our therapeutic task becomes that of translating these back to the patient according to their actual muscular mode of representation.

Reverting to the lack of differentiation by psycho-analysts and others of the nature and mode of operation of impediments of speech, the exception is to be found among the writings of the speech therapists. These would seem, at any rate until recent times, to have come under the leadership of the Germanic schools of thought. Latinized words are used to indicate varieties of disordered speech production, or else descriptive terms such as 'glottal stops', 'blocking', and

¹ This communication, much of which was pre-circulated, was first presented at a meeting of the British Society of Psycho-Analysis on 21 March, 1962. Pre-circulation enabled the further presentation of additional data too extensive for publication here. It also included tape-recordings and a film portraying two speech defec-tives. One of these, the case of a boy whose tongue remained immobile during speech, is here described.

'Before and after' tape-recordings of patients demonstrated the therapeutic success of the rationale here presented. These included a recent 'after' recording of the analytic case, i.e. of major improvement amounting to *manifest* rather than complete cure. It is much regretted that the instructive nature of this difference cannot be detailed.

'clicks'. It was only, however, after having freed a child (the subsequent description of whose case material will give indications of my therapeutic rationale) from a 'click' impediment that I chanced to read of the great linguistic interest of this phenomenon. It would seem that 'clicks' not only give evidence of the evolution of speech in mankind, but still characterize the languages of certain primitive peoples. Nevertheless I remain unaware of 'clicks' in the lalling or infantile verbalizations of children in Western cultures, and must therefore conclude that these are as much a learned activity as are the songs characteristic of the different species of birds.

For the provision of a scientific substratum to my present clinical findings and conclusions it is necessary to refer to a previous publication (1960), since the data and formulations there contained are integral to them. The following, however, requires reiteration. Thanks to a suggestion made to me by Lord Adrian, we are reminded that all the most exact and versatile skills of the tongue, with the partial exception of the imitative learning of speech, are non-visually derived and exercised. Therefore it is to be assumed that these lingual attributes belong, except in the congenitally blind, to a *different order of cathexis and of mental representation* from those pertaining to most, if not all, the other body surfaces, such as we can look at and touch on our own person, or on that of others. Furthermore, the tongue, because of its particular anatomical position, its functions, and its innate suitability for the displacement of *normal* symbolisms, or in consequence of fixations or regressions (leading to *secondary* sexualization), tends to be 'overlooked' both by the subject and the observer. We conclude, therefore, that the lag, to which allusion has been made, in gaining more precise knowledge, at any rate of the *modus operandi* of speech defects, is partly explained by our innate, i.e. non-visual, neurophysiological, endowment and by its persistent reinforcement through these common modes of psychic 'overlooking'. In any event we, as analysts of recumbent adult patients, conduct our work with speech defectives in the most adverse observational situations. Hence my good fortune in analysing a boy with severe 'impediments' who sat facing me, as did the 'tongue-swallowing' case reported elsewhere (1958). Indeed, the clinical conclusions to be presented, drawn as they are from the therapeutic observation of about twelve recent Child

Guidance Clinic cases of psychogenic speech defect, should be regarded as the further application and development of my published findings and hypotheses (1960). Nevertheless, as already stated, my indebtedness for acquiring the ability to *look*, or of becoming able to deduce, with the final capacity for explanation to him, of the modes of production of his dys-synergic mechanisms, belong to the analytic child patient who came into treatment over ten years ago. In brief, these dys-synergias were causative of disordered pronunciations, explosive noises, respiratory spasms, as well as a variety of visible tics. However, it is in respect of the *mechanics* of these and other impediments of speech that it may be useful to anticipate a paradox. Although by implication I am clearly critical of those who do not discriminate between one type of impediment and another, yet I shall be postulating the *common likelihood of operation*, in many impediments, of just *one, initiating, disruptive tic*. This tic will eventually be described, in accordance with its psychodynamic function, as a 'thwarted lisp'.

Before describing the analytic case, it may be profitable to remind ourselves that both 'impediments' and tics are classed among the pregenital conversions. In my view, such a classification need not always be correct, as it is hoped to show through this case.

Peter came into treatment when he was 6½ years old, having been referred on account of extreme shyness and diffidence at school, as well as a variety of speech difficulties. It soon became apparent that he was subject to a changing variety of marked tics and tic-like gestures, many of the latter occurring independently of speech. In addition to grimacings, noises, gestures, and jerky flounderings, which at one stage during treatment would, allegedly, clear his end of the Underground train of fellow passengers, there was also a range of spasmodic tics of his face, neck, arms, or feet which occurred as the accompaniment of his efforts to speak. As a consequence, he might shoot out a swift fusillade of words of uneven clarity, which were usually brought to a sudden meaningless halt by a respiratory spasm, or he might stutter over the beginnings of words. Or Peter might convulsively fail to begin to speak, owing to spasmodic, respiratory blocking. Furthermore, it was noted that many of his efforts to enunciate were accompanied by looks of pain, or else by a curiously

stiff sideways turning of the head on the neck. If his phonatory efforts became intensified, then tic-like spasms were likely to appear in his limbs as a kind of reinforcing, yet counter-ing, mechanism; i.e. these movements were the indicators of his exertions to combat his various oral or respiratory 'impediments'. At other times a run of speech would be fragmented by either a stammer or a stutter. However, while clicks were never in evidence, Peter used to produce 'splonks' in different keys to the varying accompaniment of salivary sounds. In despite, however, of all these aberrations of phonation, except when he spoke indistinctly, there was no difficulty in understanding him, for, as will be shown in a clinic case, incomprehensibility bears no relation to the multiplicity or complexity of (Peter's) 'impediments'. The importance of distinguishing differences such as these, as already stated, cannot be overstressed, since they may afford straight leads to the therapeutic decipherment of a psychosomatic portrayal of subjectively insoluble conflicts.

Peter's history and environmental background, which were learnt piecemeal from his long-suffering mother as well as from his borderline psychotic father, are as follows. Until he was 4½ years old, he lived as an only child with his mother and maternal grandmother. The presence throughout these years of the grandmother's amiable common-law partner, i.e. of a father figure, was suppressed until much later in treatment. Until that age, Peter's father had been finishing his service as a conscript in the Army. The boy was said to have been lively and talkative and to have been reared in a permissive and affectionate environment. As soon as the father joined this family circle, he expressed extreme anger at his son's easy-going ways and upbringing. He announced that henceforth Peter would be sharply disciplined. In fact, this peculiar obsessional man, with his abnormal pre-occupation with house-cleaning, proceeded to correct and badger his wife and child unmercifully. By the time the three had moved away to other premises, he was declaring his extreme hatred of his son, a sentiment of which he has always appeared proud. He, too, had been disliked and humiliated by a father who had preferred a younger daughter. When Peter's sister was born, she became the magnet for the father's display of inordinate sentiments, i.e. of a pathological affection for her

and detestation of the boy. Peter had begun to stammer within a few months of his father's return, before school life had begun. His speech defects, thereafter, were to increase in type and intensity, together with tics and tic-like movements. As he grew older, Peter progressively displayed great rudeness and anger towards his mother, somewhat in the manner of his father towards them both. By the time he was referred for treatment, although he was fearful of contact with everyone outside the home and his play was solitary, he was capable of swearing volubly at his father, even within the hearing of this man's fellow employees. It was then also reported that Peter was prone to sudden outbursts of brutality towards his 2½-year-old sister.

The first understanding of Peter's strange and varying aberrations of muscular volition, of which speech was the most consistently affected, came by way of a kind of tic of the eyeballs. Its presence served to enhance the rigid and unvarying stillness of posture in which he continued to sit in my presence. This stillness was, however, frequently shattered by his spasmodic phonatory contortions or noises and by his various tics and gesturings. Sometimes, while sitting at his most immobile, his eyes would roll slowly to the extreme left or right, or else would roll stiffly to an upward angle. It was clear, as he admitted to me, that by staying still, one could 'watch the watcher', a grossly criticizing role unendingly filled by his father. But it was only when Peter began to complain of headaches that the painful strain produced by these slow-motion eye movements came to be realized. Tele-scoping the essence of very many months of work, it was not until he was told of the physical pain he must be secretly causing himself to suffer that it was possible to penetrate, with his agreement, into the hidden mechanical modes by which he evoked lingual sensations. These were induced through the imposition of movements, some being of the nature of painful procedures. The eye movements had first begun to yield, once it was agreed that he could produce 'feel' without even changing his rigid stance, let alone needing to touch or press his eyes with his hands. By then, one could be confident that a circumstance which had been learned of from his mother was being enacted inside his mouth, through the medium of unconscious miming. Let me anticipate the qualitative nature of

this kind of enactment by according to it my descriptive title of other less unusual cases. To me Peter's secret, *because hidden*, actions (this being the unusual aspect here) served as an example of the tic-like condition which I have named 'testificatory gestures'.

The frightening situation to which Peter was, thereby, mimetically testifying was the following. For years past Peter's father, as his wife was to reveal to me, had made a practice, in the presence of his wife and children, of handling his scrotum and testicles through his trousers, telling of his frightful sensations and groaning with pain and anxiety. He often betook himself to his doctor, and thence sometimes to hospitals, in order to be assured he was not being threatened by excruciating anguish and sudden death consequent on testicular abnormality. Even from my brief account of this, actually paranoid, father, it can be assumed that the ambivalent triumph and fear which Peter went on experiencing, and to which he was expected to react as if deaf and blind, must have been extreme. Peter's 'rolling eye' tic began to disappear as a recurring feature, when the link was drawn between eyeballs and testicular 'balls' and how both kinds are mobile—slithery, or painful, when palpated through soft folds of skin. Only with the passage of time, however, and my progressive interpretations concerning a tongue that could be slippery-slithery when nipped or, as it were, kicked by the teeth—or, still more important within the context of the present communication, of this self-same tongue *which could go on 'behaving' as if in opposition to his conscious will*—did Peter begin to 'recognize' certain other of his sado-masochistic, lingual activities. However, although Peter knew of happenings to his tongue, he had not realized it could be he who ordained these events 'about which I don't really think, except when it hurts, and even then it won't stop doing just the same thing'. The same was true with the three 'tongue-swallowing' cases which have, so far, been diagnosed and confirmed by X-rays and others in which archaic auto-erotic lingual habits have persisted (Bonnard, 1958).

It is in a clinical context such as the foregoing that it is important to give full recognition to the special quality of *non-hysterical imperception* by which the volitional activities of the tongue are

endowed. Furthermore, the clinical consequences of a hysterical repression, or even of a true conversion, of which Peter's 'testificatory gestures', enacted by and upon the tongue, must be one type, would secondarily merge into this innately subliminal type of lingual 'non-cathexis'. Indeed, the psychosomatic subclause of the title of this paper, in part, also relates to this especial order of psycho-physiological merging, as follows. The supposition here made is that it is the non-visual, seemingly, passive-responsive, i.e. reflex-like 'properties' of the tongue, even in the realm of imitative action, together with its autonomy of accurate functioning even from before birth, which predispose it to relegation beyond the periphery of conscious attention, i.e. of ideational cathexis. The exceptions to the foregoing would be found in those perversions in which the tongue comes to be utilized as a genito-erotic substitute.

If these premises be correct, it is suggested that the kind of oral symptomatology here under discussion, i.e. many 'impediments' and ongoing infantile, addictive, lingual practices (these being legion according to the orthodontists), require a psycho-pathological category of their own, i.e. one which is neither pre- nor post-genital. Indeed, as it is hoped to indicate, it may well be that this type of psychosomatic *displacement* through volitional channels, rather than conversion, devolves on an affective confusion between the sense of veto against the *force* of autonomous drives, such as aggressivity in its true energetic sense, and the ego-assertive *aims* of these drives (see Solnit, 1961).² It is tempting to consider the foregoing in accordance with Schur's use of the term 'somatization' (Schur, 1955). Doing so will lead me to the premature introduction of one of my clinical conclusions. 'Re-somatization' (linked by Schur with primary process mechanisms) is to be regarded as a regressive phenomenon. However, as Schur is aware, spoken speech is the somatized mode of expression of psychic processes, whatever the metapsychological nature of the latter. It will be my contention that the 'somatization' here to be exemplified belongs to an order which is intrinsic to the organs of phonation and in especial to the tongue. The 'somatization' here in question relates to the translation of *intrapsychic mechanisms* such as 'undoing', into *muscular channels of representation*, of which the symptomatic outcomes are 'impediments'.

Reverting to Peter and his development: there

² Access to Solnit's contribution post-dates the original presentation of this paper.

seems to be sufficient evidence of his attainment of the phallic level of psychosexual functioning, before his father's homecoming. Furthermore, this boy has a strong ego and superego, albeit regressively suffused with anxiety and sadism. The psychic mechanisms he employed, such as 'identification with the aggressor', enacted on others as well as himself as both aggressor and victim, especially within the arena of his mouth, were of the nature of ego defences. Regressions, including overt mimetic gesturing, involving the face, eyes, neck, and limbs, had occurred in consequence of the (imposed) blocking of all realistic channels of discharge of anxiety and aggression, with a consequent defusive release of sadism. These tic-like 'testificatory gestures', insofar as they also came to be discovered to lead their unseen existence within the oral cavity, had added their disruptive quota to Peter's 'impediments' in a psychically rather than a motorically atypical manner. Peter, in fact, exemplified the ordinary lingual and phonatory countering efforts by which 'impediments' of the spasmodic types come about, as well as other tic-like movements, i.e. 'testificatory gestures', both of which involved the same muscle systems. The lingual/oral confluence, in Peter's case, of two different symptomatologies, of which the latter is rendered topographically subject to the lingual phenomenon of volitional imperception, while not symptomatically unique to the tongue, is likely to be so in its clinical and therapeutic implications. This quasi-physiological merging of which the lingual consequences resemble a hysterical repression, devolves instead on innate, non-visual functioning, on to which the directive focalization by the therapist (as will be described) would seem to work like the lifting of a repression.

According to my experience, it is these innate phenomena of imperception deriving from a cerebro-motor substratum which help to explain the notorious intractability of impediments of speech. If their intractability be doubted in psycho-cerebral terms, we have only to study the photographic material published by Klara G. Roman (1960), by which she illustrates the parallel disruptions created by speech impediments in the sufferer's handwriting and even in some cases the spelling. Roman's examples of faulty handwriting and spelling show these to be stereotypies of dysfunctioning which reflect the pattern of the subject's 'impediments'. Evidently the microscopic 'try-out' movements, which are thought to take place in the tongue

during the mental activity of thinking in words, in these cases operate according to the 'gestalts', not of their alphabetical units of spelling, but rather of their spoken sound production, i.e. of its disruptions, slurring, and elisions. Therefore, in these instances their phonations (motoric-auditory) take cerebral precedence over their mental visualizations of the printed or written word. It is clear, therefore, that the volitional correspondence between the tongue, the verbal image, and the hand, in the act of writing, can be total. We have to assume that such a correspondence bespeaks the laying down of neural patterns of discharge, i.e. of facilitating neural arcs. If, then, we were to consider the foregoing in terms of instituting corrective mechanisms of speech, we could only conclude that powerful suppressors would be needed, functionally, to offset these neural arcs or stereotypies of motor discharge in a chronic case. Such would seem to be the rationale underlying the countering procedures of some speech-therapists. But, as it is hoped to show, many impediments of speech are in fact the outcome of unconscious, 'suppressive' actions. Accordingly, therapeutic freedom from these actions should be instituted by bringing their lingual mechanics and their defensive content into the realm of the patient's conscious perceptivity, i.e. for the first time.

With this apparent digression into the psycho-neural basis of chronic 'impediments', we revert again to Peter in terms of his character structure. Like so many speech defectives, this boy, whose symptomatology might tempt us to class it as hysterical, was, in fact, markedly obsessional. It is significant that such a character type holds true of several of my clinic cases, although they do not happen to have an obsessional parent, as does Peter. Nor are these other children, as yet, unduly afflicted by the pathogenic, characterological, resultants of an ongoing, all-pervading disability. Indeed the ego development of these children, with one exception to be mentioned, a depressed boy, seems to be of normal, or even greater than normal, strength or precocity. Bearing this frequency of obsessional character type in mind, let us now consider the countering or suppressive function of certain of the actions underlying his 'impediments', as this was discerned by Peter and myself. In order to thwart his unmanageable tongue, i.e. to offset the stereotypy of its elusive malpositionings—this realization being one of the major therapeutic steps required

in the necessary achievement of lingual 'awareness'—he would either 'breathe past it suddenly' or else grip or nip it with his teeth. Or, so as to forestall his teeth from nipping the tongue in a particular (sore) place, he might run its underside along the top edge of his lower teeth. The day came when he could be asked and could show me the raw gashes on the underside and the sore teeth marks on its upper left margin. These explained the look of pain which accompanied a curious sharp turning action of his face towards the right, which I had always associated with a fear as to who might, unexpectedly, appear at my consulting room door. From then on it could be noted that, as and when his tongue became truly entrapped by his upper and lower teeth, this gripping action would start off a spasmodic (offsetting) closure of his pharynx and glottis. In the midst of these spasmodic offsettings, at both functional 'ends' of the tongue, Peter might then either try to enunciate explosively on no tidal air, or he would begin another cycle of stutters, spasmodic respiratory noises, or stammers, i.e. motility combined with dynamic inaction. The 'splonking' noises could, also, now be understood. These were caused by the tongue's quick humping/tugging action away from between the biting teeth. The obscuring features of these lingual psychosomatic enactments (which also pointed the way to their resolution) was that an increase in range of 'impediments' here served as the displaced and hidden channel of representation of a bizarre genital perversion, one which was overtly practised by his sadistic but otherwise punctilious father. Clinically, or even therapeutically, speaking, these enactments also obscure the underlying run of intra-oral events, even in Peter's case. Any account of it is incomplete without the inclusion of yet another, thwarting, mechanism, one which *disruptively underpins* these as well as Peter's and others' more common 'impediments'. Its nature is that of a *specific countering lingual tic*, one which is psychosomatically expressive of ego hesitancy, in accordance with the mode of an obsessional (would-be corrective) defence mechanism. As already stated, its descriptive definition is that of a 'thwarted lisp'. Peter's countering and pain-promoting lingual actions, as already described, should therefore be understood as having been progressively superimposed by way of the mechanism of conversion, on the *resultants*

of this underlying tic, thereby creating additional 'impediments'.

In order to give the psychogenetic background against which this otherwise undetectable tic (the 'thwarted lisp') gradually came to be discerned, mention should here be made of the following. In the earlier phases of Peter's analysis, I was acutely aware of my own sense of anxious discomfort when having to watch his effortful strivings to converse with me. This sense of anxious discomfort is a well-recognized social reaction in situations of this kind, one which, in my view, further explains the lag in our knowledge of 'impediments', in that it induces an inhibition of our clinical perceptiveness. But it is a social reaction in respect of which the dictionary definition (*Concise Oxford Dictionary*) of conversation as 'The action of living and having one's being in and among' should command our admiration, since, in summarizing the manner by which we acquire speech, it leads us straight to the sources of this complex, socially derived, inhibition. The baby, as we notice, discerns that its wishes can be even more effectively conveyed through its imitation of those sounds which are repeatedly used in particular contexts by its environment. These adaptive devices of verbal imitation then turn out to be not only useful, but even vastly entertaining. Thereby the baby can both engage its own pleasurable interest and that of its human and sometimes even of its animal environment. Successful imitation of vocal sounds, in that these require the infant's close attention, for which effort it is richly repaid by the interest *par excellence*, in mutuality. In the absence of this last, only the poorest and most primitive of vocabularies is likely to develop. Therefore, the dictionary definition of 'conversation' would also serve to describe 'mutuality', as a psychic experience.

The recognition that speech, as communication, develops as a differentiated expression of mutuality is of paramount significance. Yet, for the average infant, in that speech is acquired as an advancing ego-capacity, not only does its possession presage potential freedom but, in later years, freedom of speech is the sociological yardstick of freedom of the whole individual. On other more symbolized levels, as exemplified, for instance, in the qualities attributed to the sharp tongues of weak women, or in primitive art,³ not

³ Especially, perhaps, in earlier Mexican art, with its representations of disembodied tongues passing between personages.

only are speech and the tongue rendered interchangeable, but both serve as the representatives of the volitional ego. Recalling the fundamental mutuality of speech, including as it does the executant function of the tongue as one's first, permanent and most versatile 'scanner', we can recognize that our unease, when confronted with the speech sufferer, also stems from phylogenetic sources. The tongue responses by which sighted children learn to speak are both reflex, just as yawning may be, and quasi-reflexive, insofar as the tongue reciprocates, non-visually. Many mouth and tongue movements are, in fact, responses of a reflex, as well as of a reciprocally, postural-reflexive nature, as described elsewhere. Therefore, when the observer experiences that the would-be communicant is prevented from speaking despite his volitional struggles, the anxious scene becomes one which is shared both on reflex and reflexive, as well as other primal levels of mutuality. However, since the speech sufferer is also subject to the same inheritance of reflexiveness, he in his turn reacts to the observer's state, sometimes with the affect of anxiety serving both as a premonitory signal and as a summation point of a common unease. Many speech defectives know themselves to dread the disturbed reaction they are about to evoke in the observer, especially if he is unfamiliar or is in any way to be feared. It is quite important for the therapist to be no less aware of his unwitting reflexive contribution to this adverse situation, knowledge which he should convey to the patient. Nor, in my view, should this situation be regarded as evidence of the subject's exhibitionistic desire (unless this also exists) merely to 'hold' one's individual attention, as has been propounded. In any event, it has become possible for me to claim immunity from these disquieting reactions, because my full attention is directed elsewhere. My present-day task, once furnished with the fullest anamnestic history, is closely to watch the *mechanical actions* which produce 'impediments'. It should be briefly reiterated that the anamnestic picture often exemplifies obsessional features in the patient, such as doubt, uncertainty, or a marked contradictoriness of behaviour, as for example, in Peter's case, timidity and flagrant obstinacy. So, too, as in his case, the environmental exacerbaters of these ambivalent features may prove no less clearly recognizable, and where, as is more usual, these exacerbaters are of a less pathological intensity, such information stands us in good therapeutic stead.

The frequency of these obsessional or ambivalent features is underlined in order to introduce the following. It is my common finding, in respect of the spasmodic types of impediments of speech, that the previously mentioned initiatory lingual tic functions as the *somatic counterpart* or physical expression of a *psychic mechanism*, that of the obsessional device of defensive 'undoing'. Although akin to Schur's 'somatization', it is not identical with it, in that, as he recognizes, speech is the ego's somatic channel of expression. Before proceeding with its rationale, two of the commonest impediments of speech must first be mentioned. One of these, the simple interdental lisp, does not belong to this category of 'undoing', while the seemingly uncomplicated stammer may do so. Yet both these impediments may prove equally intractable, on a motoric discharge basis, albeit for quite different *genetic* reasons. The lisp is an overtly infantile mode to which little social objection may be made, especially with little girls, until such time as chronicity has entailed the laying-down of neural psychomotor arcs. By contrast, the uncomplicated but troublesome stammer often presents the clearest expression of that state of uncertainty or doubt by which so many of these speech sufferers are characterized. Its form is that of a psychosomatic ambivalence which may actually carry the signification of a 'No' offsetting a 'Yes', or else that of a more generalized *manie de doute*, transposed, i.e. not converted, to the lingual, i.e. the somatic agent of ego volition (human speech). However, a stammer, other than an uncomplicated one, may also be a concomitant of other 'impediments', or its intrusions into the latter may be the disruptive cause of yet more 'impediments'. In parentheses, it might be of interest to state that my clinical successes have thus far been greatest with the manifestly more complex or unusual-sounding 'impediments'. Although this may seem surprising, the reasons will be progressively indicated.

In all the welter of sounds and silences which characterize the spasmodic types of 'impediments', attention is now directed to a hitherto unrecognized, initiating, lingual tic, here described as the 'thwarted lisp' action. As was postulated at the beginning of this communication (see references to my 1960 paper), this tic belongs to an especial order of lingual imperception, i.e. of conceptual non-cathexis. Therefore, although its presence and consequences are regarded as the pathognomonic underlay of

many spasmodic 'impediments', its existence stays unperceived by the subject and, hitherto, by the observer. The following account of its psycho-motor rationale will also serve to indicate its psychogenetic significations. In clinical practice and observation it has been established that, in these cases, an unconscious thwarting action is brought into operation, as a veto against a special postural movement of the tongue. This movement is one which is necessary for the correct enunciation of such sounds as 'd', 'l', 't', 'n', 's', 'th' and the rolling of an 'r', for which function the tongue has to upcurl in order that its blunted tip can come into tactile apposition with the back of the top front teeth, or with the hard palate nearby. The 's' and the 'th' sounds are those most commonly recognized, both by the subject and observer, as constituting phonatory hurdles.⁴ If this up-curling, touching action be now considered in terms of its constituting a postural 'gestalt', then its midway position could be described as 'lisp-wards'. It would seem that this lingual tic is compulsively directed *against the archaic affective connotations* of this 'lispwards' movement. If the thwarting action stops at this point, i.e. of incapacitating the tip of the tongue from reaching its correct tactile target, then only a dyslalia, i.e. mispronunciations, become apparent. What seems to happen in cases of spasmodic 'impediments' is that further corrective, i.e. countering lingual moves against these actual or threatened mispronunciations are instituted at this juncture. Since the operation of the tic is a motorically disorganizing one, that which is experienced at one level as a threat of impending mispronunciations, on another becomes that of an awareness of inevitable lingual disorientation. This is all of which the patient is *consciously* aware. In consequence counter-countering actions are then instituted to offset the sense of lingual disorientation. It is these which then result in further dys-synergic 'collisions' between the *physiologically disparate* phonatory systems, including sometimes of respiration, i.e. a kind of disruptive chain reaction of dys-synergias of aberrant sounds and silences is set going between the tongue and the other motor, phonatory systems. Because, however, the *requisite* lingual action for correct pronunciation goes on operating autonomously under psycho-neural dictates, the consequent recurring autonomous impulsion to achieve it is experienced according to the manner of an

unrelenting 'categorical imperative'. Expressed in another way, it is the ongoing 'categorical imperative' quality of a *correct* lingual impulsion which is reacted to as if to a recalcitrant instinctual drive.

This, then, is the speech defective's impasse: an ongoing impulsion must be countered by being 'undone', and the disorientative results must thereafter either be corrected or else brought to a total stop. However, just as in other obsessional conditions, that by which the patient feels driven is not the actual stimulus, which is unknown, but the compelling need to correct, undo, or offset its incriminatory effects. What then is it in this required upcurling, tactile movement of the tongue (here described as 'lispwards' according to its psycho-motor 'gestalt') which is felt to betray or to incriminate, and against which a thwarting or vetoing mechanism becomes mobilized with tic-like stereotypy? According to my clinical experience, that which must be denied by deletion is the affective implications of an archaic expression of passive strivings, as portrayed by an especial lingual 'exhibition', namely of a lisp.

A lisp, or more important, a lispings action, is generally recognized as markedly infantile in its connotations. It belongs, of course, to the spontaneous epoch of suckling expectations and of lingual abandon. Indeed, in this lispings or protrusive lingual posture the tongue is positioned like a nipple, of which only the direction and ownership are reversed. It would seem, in these cases, that a kind of affective/instinctual confusion occurs when contrary responses to the many kinds of 'Don't touch' vetoes of the infantile era of upbringing impinge on the correct motoric stimulus of these forward-directed lingual upturnings. The countering tic which is being described is then brought into 'un-doing' operation against the *direction of the preordained lingual path*, passing, as it must do, through the half-way station of a lispings action. This is possibly why the lingual rearward positioning for the 'l' sound, as when terminating 'spell', can sometimes be pronounced, while the more forward introductory action of 'l' as in 'lemon' may give rise to difficulty. If this rationale, including that of the 'thwarted lisp' tic, be correct, then we cannot but be reminded of Coriat's insistence that these speech defectives perpetually enact the suckling situation. However, suckling and its tactile pleasures are but the

⁴ Interestingly enough, all the sounds listed are described as 'fricatives' by the phoneticists.

prototype of the vitality of instinctual drives and of interpersonal exchanges.

We come now to the more usual ways by which some speech defects may develop, whether by beginning as a mechanical fact or as a vulnerable psychic state, of which the ingredients are likely to be doubt, anxiety, or even fear, probably operating in the presence of instinctual assertiveness, i.e. of potential oppositionalism. Some children, in whom the condition is often a fleeting one, especially if their external environment is permissive, are would-be spontaneous chatterers. Therefore, because of the press of their thoughts and ambivalent impulses, they try to speak faster than their enunciatory powers can manage. One consequence may be that, as their words collide, or superimpose themselves one on the other, a result which is known as 'cluttering', it is the tongue as their executant which is experienced as oppositional. In consequence, the tongue's apparent unreliability of executant response may render it ego-suspect, i.e. self-suspect in terms of its alter-ego symbolism. This would be the stage of incipient vulnerability, when contrary requirements, of which the affective responses may derive from an external veto, are set in opposition to an ever-recurring 'escape' movement of the tongue, i.e. the neural 'categorical imperative'. This 'escape' movement, i.e. its lispward directional path, would, of course, be predetermined, in that it has been reflexively yet correctly acquired through previous 'trial and error'. As already stated, it is this quality of irrepressibility of an essential lingual 'escape' movement which the subject then confounds with the uncontrollability of spontaneous impulses as such. Why this upward lingual movement towards dental or palatal touching becomes incriminated is difficult to understand, except in archaic terms of vital impulsions, such as ingestion or suckling, and its opposite, namely elimination.

The psycho-sphincteric patterns⁵ of control and discharge of unmasterably mixed affects (in which the anlage of pre-regressive obsessional reactions is, perhaps, to be found), was dramatically brought to my notice some fourteen years ago. A 3½-year-old girl was seen at the clinic as an emergency. Several times in the preceding

week, but since the previous day terrifyingly so, the child's mouth became fixed in a wide-open position whenever she attempted to speak. It was ascertained that attitudes of the most rigorous order of habit training were imposed at all levels by her pseudo-genteel, somewhat unintelligent, ex-nanny, adoptive mother. On a later occasion, little Dorothy turned out to score an IQ of 145, an awkward attribute in a home where her kind adoptive father, of very poor intelligence, was similarly berated by his wife. The child's spasmodic aphasia was to yield at the first interview, when linked with her fears that her babblingly inexact speech was scarcely more controllable or worthy than her demanded, but nasty, excretory products. However, there are others who, when in an affective situation analogous to Dorothy's, will succumb to impediments of speech in a much more damaging piecemeal fashion than this child who had called a dramatic halt to all verbal expressions of volition. Dorothy eventually became a tough refuser even of proffered advantages, lest she might have to go on being beholden for having been legitimized. At school-leaving age, when offered an introduction to a firm with a range of excellent opportunities, she told me she would be finding her own job, which she did successfully.

Let me outline another type of case in which the patient's unwilling speech was completely unintelligible, albeit in the absence of any manifest 'impediment', i.e. a striking case of dyslalia. This was a motherless boy of 13 years, with an IQ of 113, who had already experienced three and a half years' placement in a residential school for speech defectives. The clinic referral came through his aunt, a clerical worker in the hospital, who happened to know of my interest. When, at first interview, it was learnt from her that his crippled and deaf father is no less unintelligible, owing to a cleft palate, it seemed that the prognostic picture must be a hopeless one. So incomprehensible was the boy that he had to write out his spoken account of a TV incident. The sound 'ouaph' was then matched by him, for example, as his rendering of the word he had written as 'raft'. Fortunately the following

⁵ The overall suggestion that psychogenic disorders of speech may be regarded as a symbolized form of regression to excretory activities is misleading, in my view. The fact is that speech, superbly differentiated as it is in its motor precision, is and remains volitionally sphincteric. Symbolic correspondences between the activities of orifices, underpinned as these are by the patterns of

maturational evolution of muscle-group control, are, therefore, inevitable conceptual analogues. Even the 'shocking' words, whose ejaculation would appear obsessively to bedevil some of these patients, sometimes turn out to be last-ditch attempts at breaking a distasteful impasse, a desperate form of 'dam-busting' in all its connotations.

could easily be observed, in that his lips remained parted and static in the act of 'speaking'. It was seen that during phonation his tongue lay and remained, completely immobile, on the floor of his mouth. Examination of the high narrow roof of his mouth showed a deep furrow in the hard palate which, on request, could be seen to fit precisely to his thumb. The boy agreed he was a persistent thumb sucker. It was, therefore, explained to him that his tongue continued to remain flat so as to accommodate itself to his perpetual thumb sucking, *whether or not* his actual thumb was present in his mouth. He was advised to remind himself that his tongue could regain its liberty whenever his thumb was not there to hold it down. At his next visit, which was arranged in order to take a photographic sequence of his disability, much to my dismay and pleasurable surprise, he insisted on enunciating in a normal, if slovenly, way; as well as smiling, a previous rarity. As subsequent events proved, this insistent display of normality, when the opposite was needed of him that day, was an expression of ambivalent or negativistic oppositionalism.

This case was taken into treatment by our child psychotherapist, on account of his marked depression. It is outlined, not only because it exemplifies the pathognomic differences between incomprehensibility and complexity of speech impediments, but also because it so perfectly illustrates one of the postulates in my previous communication; this is to the effect that the tongue, as the body-ego or somatic executant of verbalized volition, remains personified according to its symbolic role of alter ego. This implicit assumption of the tongue's personification stands me in good therapeutic stead, as will be briefly described in the following case material.

Timothy, almost 8 years of age, with an IQ of 124, was brought to the clinic by his gentle, horrified mother and his quiet father, on account of his rapidly increasing speech afflictions. Having begun occasionally to stammer, stutter, and splutter from 4 years of age, he had recently become almost wholly incapacitated, especially when at home. All he could produce were contorted silences, stutterings, frantic and explosive gaspings, or short spurts of nearly incomprehensible 'blethering'. At diagnostic interview he looked abjectly miserable, hanging his head

during the worst of these contortions. Sometimes he clenched his jaws so hard that his head quivered. This was the boy, previously mentioned, who during a subsequent interview was to afford me my first opportunity of *directed* listening to, and watching of, the phenomenon of vocal clicks. My explanation of how he brought these about was to establish his most striking 'undoing', this time in the therapeutic sense. In this context a reminder is appropriate of the curious fact, described elsewhere, that for the observer to be able convincingly to verbalize what the tongue is 'up to', is often to put an end to the specialized nature, as discussed, of its compliance. This kind of subject/object lingual focusing may spell the end of these and other lingual symptomatology which, owing to their elaboration beyond the subliminal ken of the ego, can operate like 'the tail that wags the dog'.

However, Timothy had realized from the very beginning that my interest lay, not in the 'why' of his being as if possessed, as so many of these patients feel themselves to be, but in the 'how'. Therefore, when talking to him, his tongue would be spoken of as if it personified a separate entity, indeed one which was but a bagful of tricks. What, it would be asked, could this tongue of his do to plague him successfully, even while clenching his jaws to stop it? Evidently it could go on tripping and tricking him, even when he tried to gasp his way past it. Or, when he tautened his gullet in order to keep his tongue still, it could yet twist a word or could even stick itself right out in the rudest way. Commiseration was expressed that fingers cannot be used to make it go or stay in the right place, so what could Timothy hope to do to master his naughty tongue? At these allusions to rudeness and naughtiness, which he was assured that only we could guess or know about, Timothy laughed convulsively. Through such animistically couched exchanges and abjurations, the latter being appropriate in the light of one's knowledge of Timothy, the notion was quickly conveyed that he had but to set out to catch his tongue in its trickery, for him to begin to make it 'come to heel'.

At the fourth interview, Timothy, who was already enjoying longer and longer spells of normal speech, looked anxiously embarrassed by the strange clicks which were to punctuate his conversation. Luckily, it was possible to

see a click happening, and so the fantastic acrobatic feat which had just been accomplished by his tongue could be explained to him. The correctness of my explanation was proved by Timothy's next and last click. For its production his tongue had, in one lightning movement, to be overcurled far backwards and to have much of its underside pressed against the back of the hard palate, i.e. a gross exaggeration, through overshooting, of the required but vetoed forward path of dental or palatal touching. It would seem that this kind of tongue apposition creates a suction vacuum between its underside and the palate. It is the breaking of this vacuum by a smart forward flicking of the tongue which produces the click. Interestingly enough, and as one has come to expect, although Timothy agreed that this is what must have been happening, he was thereafter quite unable to reproduce the click voluntarily, his efforts then becoming variants of 'cork poppings' to which the 'click' bears no auditory resemblance.

Although all his naughty impulses had, in previous interviews, been strictly relegated to his personified tongue, Timothy had always understood me quite well. *Pari passu*, he had also come to realize that my role was chiefly that of a true ally, once his charming mother had agreed with me, in his presence, that she was a fussy who became readily scared over practically anything that could happen spontaneously or without warning. For her, such potentialities are reacted to as if to a breakthrough of bad manners. Timothy adores his mother, whose feelings he is terrified of hurting except with her permission. This she was soon able to understand and agree. Interestingly enough, at the outset of these therapeutic encounters, his quiet father, who had been an active paratrooper during the war, was at the point of burning his boats and losing his pension security, by resigning from his post. For years past he had worked for inadequate pay, behind the bookshelves of a learned institute. He had taken the leap into similar, but remunerative, commercial work. When

we knew each other a little better and he was being urged to let his son realize, from his father's outdoor behaviour, that a successful ex-paratrooper is nobody's sheep, he told me he could only behave or express himself strongly, were someone else's life actually being endangered. Less than that could mean 'You might be interfering, or rude, or mistaken'. Timothy, however, continues to embolden himself and to be mainly free of his impediments, except when worried.

Unfortunately, in the interests of brevity, discussion of the tension-promoting or exacerbatory factors in this type of case, important not only because of its immediate psychodynamic relevance, but also because of the lack of gross pathogenic elements, both in the patient and in his environment, can only be brief. Timothy's mother agreed that her uncontrollable reaction to 'unexpected' behaviour, i.e. her mode of 'nipping it in the bud', was to display vivid horror. It is assumed that at this child's maximal experiencing of the freedom and pleasure of spontaneity, this became confusingly 'proven', through the fear written on his mother's face, as the nascent moment of break-through, i.e. of instinct-laden culpability. 'Instinct-laden culpability' would be another way of describing the quality of that which must be defended against by means of the 'thwarted lisp' action, the lisping posture being the hallmark of an uncontrolled revelation of a fawningly passive or 'silly' inviting fondness.

It is not uncommon for the onset of impediments of speech to be linked with major childhood events, such as the beginnings of school life, the birth of a sibling, or with surgery such as tonsillectomy. In such instances, whether or not these correlate with predisposing fixations or with certain environmental constellations,⁶ it seems likely that the patient has experienced an overwhelming sense of threat to his ego-executant autonomy. My clinical surmise, in respect of the analytic findings from such children and from favourable adult cases, would be that what was felt to have been overpowered or

⁶ Three types have so far suggested themselves: (1) That in which undue censure and denigration are the order of the day, as with Peter and Dorothy. (2) Where parents are at loggerheads, each fostering or alleging the other's dislikes or faults (in the child). (3) Timothy's case, which can be psycho-maturationally paralleled in many different manifest contexts, i.e. where the sense of reprehensibility becomes the (conscious) price for the strength rather than the nature of instinctual assertiveness. It is a well-known fact that many speech defectives

do not lack good intelligence and are people of tenacious courage, especially in the face of challenging adversity. Yet because of the humiliating and isolating nature of their disability, few are to be found in the higher ranks of business or the professions. In that the clinical evidence also points both to the strength and the sensitivity of many of these sufferers' ego capacities, this serves as a reminder that the same can also be said about the subjects of other types of psychosomatic malfunctioning.

rendered unreliable was their most assertive channel of self-expression, assertive because hitherto it had been unequivocally spontaneous. Whether or not such a situation activates fixations or else intensifies castration fears owing to the predisposing body-ego equations between the tongue and the phallus, we know that persisting impediments of speech are largely

associated with the male sex. The alleged exhibitionism with which these symptoms are sometimes linked would, therefore, seem to me to find its most likely niche within the ramifications of these patients' desire and fear of the assertive irrepressibility of the *agency* of their self-expression, of which speech affords the most versatile evidence.

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ANALYSIS OF A WOMAN WITH INCIPIENT RHEUMATOID ARTHRITIS

A Contribution to the Understanding of Somatic Equivalents of Withdrawal into Sleep¹

By

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The observations and concepts presented in this paper were made and formulated over a period of some fifteen years, during an attempt to understand better the relationships between psychological variables in the so-called psychosomatic disorders. In those years as a teacher, psychiatrist, and analyst I had grown more and more dissatisfied with what I read, heard, or said myself on the subject. Yet I realized that I had collected and kept talking about a number of seemingly disconnected clinical observations and theoretical ideas which I felt were related in some way. But try as I might I did not know how to make them fit together. About eight years ago I undertook the analysis of a young married woman who had a phobia about becoming pregnant, and who developed, during her analysis, symptoms of rheumatoid arthritis. It was in the course of this analysis that most of my amorphous thoughts crystallized for me.

This paper is mostly concerned with reporting the analysis of that woman, and how her associations inevitably led me to the conclusion that sleep as a gratification and withdrawal into sleep played a major part in her symptomatology and character structure. As I understood that fact, I gradually realized that the unrelated observations and ideas which I had collected over the years admitted a common denominator: they were or could be an unconscious attempt in the face of intolerable stimuli to protect oneself by falling asleep fully or partially at the symbolic as well as the physiological level.

I now understand, for example, why many years ago in Rochester, while observing Monica W., the baby with oesophageal atresia so care-

fully and extensively studied by G. Engel and F. Reichsmann (1956), I found myself vaguely dissatisfied when she or her mechanisms of defence were described. I felt that somehow, somewhere, a part was missing in that picture. I reasoned that the maintenance of life requires positive elements; gratifications and pleasure are necessary supplies without which infants must die. Sick as Monica seemed, she was hanging on to life and was capable of adaptation, albeit in a narrow range. Where was her source of gratification? Where did her pleasurable supplies come from?

I was looking for the presence in her 18 months of life of a stronger more positive pleasurable element than was apparent to me. Engel and his co-workers described the beneficial influence of a good grandmother in the first few months of her life, they also recognized and described how sleep alleviated her distress and was an important part of her conservation-withdrawal response. But to me this was not enough. I now believe that sleep is a much more important source of gratification than is generally recognized. Margaret Ribble some twenty years ago stated that sleep had become the *only* source of gratification of Baby Pat. Freud first pointed out the function of the wish to remain asleep and the role of dreams as the guardians of sleep. Finally, Bertram Lewin demonstrated the crucial role of the wish to sleep at the psychological level in his formulation of elation.

In this paper I hope to demonstrate how under certain circumstances sleep, a normal physiological reaction, might not only be used as a way of avoiding unpleasure, hibernating (Ribble,

¹ Revised and expanded version of paper read on 5 May, 1962, at meetings of the American Psychoanalytic Association in Toronto.

² Associate Professor, Albert Einstein College of Medicine.

1946), conserving energy (Bibring, 1953; Engel *et al.*, 1956), but also belonged for unconsciously as the main source of pleasure symbolically and physiologically. Based on this fact I would like to raise two questions. The first is whether sleep and its physiology do not play a part in the phenomenology of many other emotional reactions such as some psychosomatic disorders, altered ego states, and the psychoses. The second is whether this combination of defence and gratification is not similar to that described by Lewin in his oral triad, and is not applicable to a number of other reactions seemingly unrelated to elation.

Because I feel that to preserve more or less the order in which ideas presented themselves to me will permit a clearer and more convincing development of my theme, I would like to organize this paper in the following fashion:

- I. Clinical observations—based on clinical material from various sources and the analysis of a young woman.
- II. First discussion relating mostly to the case material.
- III. Further clinical material from the analysis and experimental evidence.
- IV. Second discussion—general considerations on psychosomatic disorders.

I. *Clinical Observations*

My first observation was made some fifteen years ago when I saw in consultation a 50-year-old spinster, an ex-physical-education teacher, who suffered from marked rheumatoid arthritis in many of her joints. A careful study of the literature at the time proved to be enlightening but not very useful. There seemed to be a gap between the observed phenomena and their tentative theoretical formulations. As soon as one ventured outside of the accurate and interesting descriptions of the psychological profile of the patients suffering from arthritis, the literature would reveal many contradictions. This woman did not seem to have the difficulty she theoretically was supposed to have in expressing aggression or hostility in *feeling angry*. She had bouts of marked neurotic depression. These depressions were not caused by aggression turned against herself, but rather by loss of self-esteem over her inability to perform, a wasted life, and generally the fact that she had lost herself as an object. The crippling disease was a narcissistic blow which had ruined her self image as well as her ability to perform,

so that her depression seemed related more to shame than to guilt.

When she spoke angrily about her past or present her limbs seemed inert and lifeless, yet she was supposed to exhibit muscle tensions. I took this to be a secondary phenomenon caused by the marked arthritic processes. This is consistent with the observations of Harding (1929) who reported atrophies due to general disuse and attributed them to persistent pains arising in the surfaces of the joint and producing inhibition of extensor muscles. Randall (1928) had observed similar atrophies in widely scattered muscle groups and found no ready explanation for these pronounced atrophies and wasting of whole groups of muscles around the hips, thighs, and ankles.

Eight years ago, a young married woman of 27 was referred to me because of a phobia about becoming pregnant. She also suffered from severe anxiety attacks and from what she called 'depressive reactions'. She mentioned, incidentally, and in answer to my questions about her general health, that she had had a few fleeting arthritic pains in her wrists; neck, hips, and ankles. Owing to the fact that her husband was only temporarily working in the city where I practised, I saw her in psychotherapy once or twice a week for about a year. Some three years later I moved to New York City where her husband had his permanent job. The psychiatrist who had previously referred her to me was a psycho-analytic student who had presented her case as a possible control to his Institute. It was turned down, however, because she was thought by the supervisor to be a borderline schizophrenic who was too sick for a control analysis. She returned to me and we started her psychoanalysis five years ago. Her arthritis was much worse, and she now had red, swollen wrists and finger joints. Her treatment turned out to be difficult, as predicted, but this applied only to the first year of her analysis. Soon after that she revealed herself as one of those patients who quickly understand the meaning of analysis and show great ability to free associate, be self-reflective, perceive and understand many of their unconscious conflicts. The analysis of this woman was conducted without preconceived ideas about arthritis, nor did I have any special interest in arthritis when I first saw her, the arthritic spinster described earlier having been my last

and only case. I analysed her for her pregnancy phobia; anxiety and arthritic pains were just additional symptoms. The factors contributing to exacerbations of her joint pathology floated naturally and slowly into consciousness under the influence of our work on resistances and clarified themselves as she worked through her unconscious conflicts.

The formulations given in this paper do not pretend to apply to rheumatoid arthritis in general, but are rather offered as a contribution to the understanding of the factors at play in the symptomatology involving muscles and articulations. As is well known from the authoritative papers of many authors, especially Ludwig (1951), rheumatoid arthritis is a complex systemic disease in which arthritis plays a relatively small part. No attempt is made here to shed light on the important systemic aspects, since my patient lacked most of those serious manifestations, organic and psychological, usually described in the literature.

This young woman cried incessantly during the first year and presented herself as a helpless little girl who could not cope with sexuality, let alone maternity. Her childhood was a blank to her, and she hardly remembered anything before the age of 8. Hostility and aggression appeared to be unknown to her. Her life seemed to be that of a Cinderella without benefit of charming princes. She was the youngest of several sisters. Her very attractive sisters had been sent to private schools at great financial sacrifices to the parents, who could not afford to give the patient the same luxuries as were provided for her siblings. She was dressed with hand-me-downs, yet never complained. She remembered going with mother to shop for evening dresses for her sisters and understanding very well that for her high school dance mother would fix up one of her sister's very nice old dresses. Mother, a refined, attractive woman, found sex revolting, but described in great detail her suffering with each of her deliveries. Yet she became pregnant again when the patient was 11 years old. The patient assumed a great deal of responsibility for the care of her baby brother not only as an infant but also through most of his childhood; she was nursemaid and practically a second mother to him.

When the defensive nature of her crying and acting helpless was understood by the patient, she became aware of strong competi-

tive strivings with mother and had no difficulty whatever in stating and remembering countless episodes in which she compared herself favourably with mother. Not only had she felt that she could care for the baby more efficiently, but she also thought that her father would prefer her to mother since she was carrying most of the burden of running a house for him and since he seemed to prefer her company to that of mother. These thoughts and memories *had never been truly repressed*. They had been minimized and put out of focus. For example, she would recount how her grandmother caught her once muttering angrily, after being scolded by mother: 'Drop dead'.

The parents of this woman fit very well the accepted profile for parents of rheumatoid arthritis patients. Mother was without question a rejecting and dominant figure while father was meek and submissive, though a good provider. The patient abandoned her defensive crying almost completely and entered into a period of relative calm, her symptoms, including her joint pains, subsided, and a long, slow process of analysis began. A great deal of reconstruction of her past and childhood could be done. The transference was predominantly to a good mother with a minimum of sexual elements in it. At the same time that the childhood amnesia was being lifted, extreme hostility to her mother and sisters kept coming to light. She had felt unloved and unwanted by mother. She remembered mother losing patience with her at age 4, when mother had been rough while giving her a bath and later drying her with a towel. She crystallized around this episode many of her fears of mother, especially the feeling that mother might drown her or really hurt her with her big powerful hands. As this material was being slowly put together and worked through, I was struck by the fact that she held herself on the couch in almost complete immobility. Her hands, like those of my previous arthritic patient, were not only immobile but *lifeless and inert*. This was an interesting phenomenon since it occurred at a time when she had no arthritic involvement whatever and in parts of her body where she had had no arthritis. This immobility of her body and hands could not be ascribed to pain or secondary changes in the joints. Her hands, which had been fairly strong, became progressively thinner, with the extensor tendons

more and more prominent, and she showed now a notable loss of power and tonus. This seemed present to a lesser degree in all her limbs. She had become more clumsy, but in a very specific way. It was as if her joints were weaker, and as if objects in her hands could not be held tightly, and consequently would fall. The discrepancy between her ability to verbalize angry thoughts and the inert death-like aspect of her hands, arms, and general bodily posture became more and more striking. The more she spoke of wanting to bloody her mother's face with her fists, the less her hands moved. She invariably held them open and crossed over her abdomen, and it was as if she could inhibit their tonus for days and weeks on end. Whatever other factors were at play, it was obvious that her hand and wrist muscles were becoming atrophied from immobility and lack of tonus. It is not that she did not use her hands as much as other people, since she did all her housework, cooked, and held a part-time job requiring some typing. Even under forced bed rest, power, tonus, and muscle volume can be maintained to quite a degree unless other debilitating factors are at play. When this woman was not at work, her limbs were like those of a person in deep sleep. This hypotonia was so striking and was maintained for such long periods of time that disuse atrophy became unavoidable. Guilt about her impulses played an important part in this reaction, and was investigated very carefully, but something else which I could not understand was playing a part in this intermittent inhibition.

Her associations fully warranted the interpretation that her anger with mother had awakened a deeper terror of being killed by mother and that this terror paralysed her, but this interpretation only intensified her symptoms and stilled her hands even more. In spite of her dreams and associations, she could recall no such terror except a general apprehension about mother's big hands which kept making her angrier and angrier. Whenever she had occasion to see her mother, she quarrelled with her. She reproached her for past slights, made her cry and feel guilty, and derived a great deal of pleasure from this newly gained power. At this time it became evident that she was identifying herself with father, who had delicate small hands. Slight twitching and tensions would appear in her hands. Occasionally a pain would shoot

through one hand or wrist. She would get angry with her husband for neglecting his duties around the house, not helping her clean the windows, shovel snow, or take care of the furnace as father had always done. She would then energetically, forcefully, and efficiently shovel snow, wash the car, and clean the furnace. These intense energetic efforts, occurring at the time when her joints, under the effect of her conflicts, were obviously hypotonic and artificially at rest, could have only one result—the production of stress, strain and pain. The day following her efforts she would wake up with sore, stiff muscles, followed shortly thereafter by red, swollen joints and arthritic pain. I observed many times the same sequence of events precede the development of arthritis in one joint or another. *In statu nascendi* the course was always the same:

(1) Angry thoughts and feelings at a mother figure accompanied by hypotonia of one or several muscle groups.

(2) Identification with a father figure and shift from hypotonia to tensions and shooting pains in the previously hypotonic muscles.

(3) A burst of physical activity, followed by pain, muscle stiffness, and eventually red swelling and arthritis of one of the joints activated by previously hypotonic muscle groups.

These observations seemed to conflict with what was postulated by early authors on the subject of rheumatoid arthritis, especially Johnson, Shapiro, and Alexander (1947). They had stated that hostility was repressed and produced tension in the joint, and that this tension in the joint 'for some unknown reason possibly constitutional, organic, etc.', produced the arthritis. The course of events as observed in this patient was quite different. Hostility was not repressed but was fully conscious. The somatic reaction (hypotonia) inhibited the patient's ability to carry out any motor manifestation of this anger. It was as if the defence was against translating hostility into action rather than against conscious awareness of the anger. The long period of hypotonia, which could go on for months, possibly years, extended to other areas and groups of voluntary muscles in the body. This marked loss of tonus and resulting relaxation produced weakness and a loss of dexterity and co-ordination. It also seemed that this general relaxation, involving all groups of

tendons and muscle extensors as well as flexors, produced a certain looseness of the joints themselves. We can theorize that, when a sudden violent burst of activities followed close on the heels of a long period of inactivity and relaxation, the tension in the joints would press the articular surfaces in abnormal ways or areas and grind them against each other, since the normal holding and cushioning effect of muscle tonus and ligament tension was much lessened in whole limbs as well as in the involved articulations.

Muscle and ligament tension, as has been supposed heretofore, probably plays a part in producing grinding of the articular surfaces and tension in the whole joint. Yet it is difficult to understand why this should be traumatic, and how this is different from any prolonged and intense state of muscle tension which invariably leads to increased muscle tonus and development. If, however, the muscular tension and activity follows a period of hypotonus and inactivity, it is easier to understand why these muscle contractions can be traumatic and noxious to the articulations. A number of internists³ have confirmed this finding in some of their cases, and I feel on the basis of more superficial observations on a number of other arthritics that hypotonia is a *necessary, but not the only condition* in the development of joint symptoms in rheumatoid arthritis.

As this mechanism was understood the patient became aware that she had never expressed any anger at her father in spite of many frustrations and circumstances which would have made anger fully understandable. A long process of analysing defences finally lifted this *true repression* of an unpleasant impulse directed at her father. As she spoke, remembering and reliving past events and repressed memories laden with anger, she continuously moved her right hand and gesticulated a great deal while talking about her father. She had a dream in which father and mother were standing at the door of the kitchen kissing each other. In this dream while she was telling her parents that it was time to eat, not to be lovey-dovey, she pushed her father with her right hand into the dining room

and seemed to have put her left hand on her mother's shoulder, or to have nodded in her direction without touching her. In her associations to this dream, she was angry at father, at her husband, at me, talked about the cockiness which we had in common, wanted to tear her husband's penis with her right hand, and all the while never stopped moving her right hand and wrist in spite of the fact that it was mildly swollen and that some of the articulations were painful. While she continued to speak about her mother, however, her left hand remained immobile (mother was left-handed). In the following year she verbalized many tender feelings for mother, yet kept the left hand practically immobile on the couch during this whole time. In the now markedly erotic transference, her anger and frustrations led to sadistic fantasies about me which were accompanied by continuous, even though slight, movements of the right hand. For the next two years the right side almost exclusively expressed feelings and conflicts towards father figures, while the left was reserved for reactions towards mother and mother figures, in transference or in reality. At times she exhibited a left hemihypotonia,⁴ while the right side of her body was in a mild state of constant tension. She would then oscillate between expressing, in the transference, hopelessness towards me as a mother figure and in the next minute hopefulness as she shifted to muscular tensions and a father transference.

It became obvious that, as pointed out by early authors, aggression was a conflictual area in this patient. However, it also became evident that aggression directed at mother had been fully conscious, but was for long periods of time handled by the muscular hypotonia previously described. On the other hand, hostile thoughts and sexual feelings directed at father had been *repressed*, and the psychological defence rendered the somatic defence which she had reserved for her mother unnecessary. This illustrates that looking for muscle tensions and manifestations of repressed anger in this patient would not have led us very far since, depending on circumstances as well as on the object of her

³ J. Sandson, M.D., and staff, Rheumatoid Arthritis Clinic, Bronx Municipal Hospital Center, New York, N.Y. Personal communication.

⁴ This was reminiscent of Monica W., the 18-month-old child with an oesophageal atresia filmed and studied by

G. Engel and Reichsmann who exhibited a hypotonic hemi 'withdrawal depression' syndrome when a stranger stood at one side of her crib and activity in the other half of her body when her good Dr Reichsmann stood on the other side (Engel *et al.*, 1956).

anger, this woman could use two different mechanisms to modulate her defences against hostility. At this point I wondered what made the difference between these two mechanisms of defence.

I had assumed all along that anger against mother would be accompanied by a feeling of hopelessness and futility which paralysed the patient. This fostered passive submission to mother and motor discharge against father could thus acquire unconsciously a defensive function: it pleased and placated mother. In fact, this had been interpreted earlier without much result, except that the patient agreed with me. On the other hand, I assumed, I think correctly, that since her father was very fond of her and in many ways preferred her to her mother, he had encouraged her feelings by dangling in front of her the hope that she might realize her oedipal strivings. From her early teens she had been a tomboy and loved to hunt, fish, ski, and swim. In spite of these activities she could be motherly to her little brother when she was 12. In those days she and father were close, they enjoyed these pleasures together, and *he encouraged displays of motor activity*. When she was 15 or 16 years old she discovered that a friend of the family, of whom she was very fond, was his mistress. While this incensed her, it also raised her hopes that he might prefer her to mother. Tentatively, I felt that the hopelessness of coping with mother versus the hopefulness which accompanied her wishes towards father had something to do with the absence of motor discharge in the former and its presence in the latter.

While further evidence did not disprove this formulation, it became clear that it was much more complicated. The patient entered into a period of mental confusion in which she spoke of herself and a painting of mother and child in my office as if she were the mother and the child at the same time. In dreams she confused herself with a small child who was choking. In everyday life and in the transference, she spoke as if she were my wife or her mother in a semi-delusional fashion. While speaking of her fear of mother, she thought that mother would want to strangle or drown her in the bathtub. But, little by little, she became aware that she wanted to strangle herself. Overwhelmingly and unmistakably, associations made it clear that she had introjected mother and that any aggressive

act which she wanted to carry out on mother had to be directed at herself. Another element which again explained the autoplasmic nature of her defence was that her homosexual attachment to mother was clearly based on a need for union with her and a return to the womb. This was related to, or coincidental with, the flexed foetal position she temporarily assumed while asleep.

Eventually we were able to trace the origin of her defence against anger to a wish to fall asleep when overwhelmed by aggressive feelings. The infantile amnesia started to lift when she realized that all the memories that she recovered from age 4 were memories of falling asleep, being rocked by grandmother, being asleep in grandfather's lap, lying in her bed, feeling dreadful, being sick in mother's bedroom, and eventually falling into a deep slumber comparable to falling into a dark 'hopeless, threatening, and yet not threatening, hole'. In her case the *dream screen*, or the periods of blankness when she had no thoughts, were usually represented as *black or dark*. What emerged from these memories and strange somatic sensations was that at certain times, especially when she was sick and frightened, her only defence against her fears was to fall into a black sleep. It became clear that sleep was a withdrawal mechanism used when confronted with feelings and wishes for which she felt no action could be taken. She tried to do: *nothing*. Nothing, to her, meant complete body immobility. This invariably led her to sleep. She could distinguish two kinds of sleep or screen, a light or white one with her body in foetal position, which was populated by images, thoughts or dreams; being in heaven became fused somehow later in her life with dreaming or being in a dream. The dark or 'black sleep' which was often initiated by silent crying was dreamless. She relived in the present many such episodes where she would be lying *on her back, flat in bed*, tears flowing silently, slowly but incessantly. She would feel sick in body and mind, as if she were trapped in a dark hole without any way out. In her mind there would be just snatches of thoughts, 'Why don't they . . . why don't I . . . why did they, something . . . why don't I, something . . . but I don't know what. . .'. She would then fall into a kind of dark sleep from which she would awaken exhausted, with her mind dull and slowed down.

Events in her later life, such as an operation for otitis media at 6 and many illnesses, revived the black sleep of her early childhood and possibly of her infancy. But this true withdrawal into no action or black sleep became less and less possible as she grew older. It was replaced by sleep equivalents, or partial states of sleep. Every time she had reasons to be angered she became dazed, as if part of her mind was asleep, and she would enter into a mild altered ego state. As far as could be observed, the ability to make her hand and legs 'go to sleep' had appeared only in adult life. It was extremely difficult to make her aware of the equation: stillness of her hand = no action = dead hands = black sleep. This was all the more interesting in view of the overwhelming evidence in favour of this equation and her usual ability to understand symbols in her thoughts and dreams. It was as if this somatic reaction, a throwback to preverbal stages, had put her mind to sleep and was taking place in a kind of isolation, dissociated from the rest of her mind, so that her partially altered states of consciousness were encapsulated, discrete, and at times difficult to differentiate from a daydream.

At this point I would like to give a few brief clinical data. Her rheumatoid arthritis had gradually but very slowly involved her right wrist and hand with typical X-ray findings. The interarticular cartilages were destroyed, and the articular line completely obliterated in places. The right wrist had been under tension with muscle spasm for at least three years. Early in her treatment it had been at times still and hypotonic, but since I had not realized at that period the meaning of that symptom, my observations were not very careful. By contrast, the left hand, which had been held immobile for nearly two years while at rest, showed no such changes and was almost normal by X-ray. On the basis of our past experience with this patient, her internist started physiotherapy on both her hands, especially the left, when, under the influence of her analysis, she started having muscle contractions and tensions in her left wrist as she became more and more able to bypass her somatic defence. This was done in a preventive attempt to avoid what had happened to her right hand. By and large, the course of this patient was as reported by Gottschalk, Johnson and others for patients with rheumatoid arthritis who were in psychotherapy. That

is to say, her disease progressed very slowly, without the intense flare-ups seen in patients who did not have the benefit of psychotherapy (Gottschalk *et al.*, 1948; Johnson *et al.*, 1947).

I have intentionally omitted in this case history many elements which had been accurately observed by all who studied the psychological roots of rheumatoid arthritis (Gottschalk *et al.*, 1948; Johnson *et al.*, 1947; Ludwig, 1951), problems relating to penis, envy, masculine defences, sibling rivalry, identification with mother, guilt, etc. It was only after most of these elements were understood and worked through, especially the guilt over aggressive feelings, that the deeper and more archaic aspects of the defence became evident. The left hand, which had remained immobile through all the previous interpretations, started to move only when the equation of sleep hypotonia was understood affectively. She thus reported the first time that her hand moved while she was on the couch: the previous night she had slept from 9.00 p.m. to 11.00 a.m. She said, 'I felt groggy, did not want to do anything. My legs felt sleepy. I haven't slept that long since I was a little girl. I kept yawning all the time and at 2.00 p.m. I took a nap. I woke up and fell back to sleep and every few minutes I had a kind of half-nightmare'. Then as she was talking of strangling mother instead of herself, she said, 'Did you notice I made a fist and moved my left hand? When I moved my hand, I felt awake for the first time today'.

II. First Discussion:

Relating Mostly to the Case Material

From a theoretical point of view I wish to emphasize two reasons why certain phenomena could not be observed or related as long as the physiological model which was being followed, consciously or unconsciously, was that of Walter Cannon's *Fight or Flight* and Pavlov's *Conditioned Reflexes* (Cannon, 1942; Engel, 1954; Reiser, 1961).

(1) Both models relate predominantly to waking life. If my observations on this patient, and, as I will elaborate later, those of many authors in similar frames of reference, are correct, what is needed here is a model related to the physiology of sleep. For example, keeping the fight or flight pattern in mind, Gottschalk, Serota and Shapiro (1948) stated, 'Patients with rheumatoid arthritis were felt to be particularly

sued to the study of the interrelations of psychological conflict and muscular tension because of their preoccupations, conscious and unconscious, with the latter'. Yet their results, as well as those from the studies of Southworth (1958) and Mueller and Lefkovits (1956), conclusively prove that muscular tension was not greater than that found in any other patient suffering from so-called psychosomatic disorders.

(2) Moreover, Cannon's and Pavlov's models are quite valid for young and adult animals, or for humans who have reached a fair to high degree of integration at the physiological as well as psychological levels. They fail, however, to furnish a physiological basis for most phenomena observed in the very young of the *altricial* species, which are so immature at birth. In their case it is almost useless to think of flight or fight, since they do not even have the necessary motor equipment for such reactions. Yet Anlagen of fear and flight reactions exist in all altricial young. Without minimizing their importance, however, one can safely say that their main value under average expectancy conditions is to serve as a signal. This signal is a communication to the mother who has the necessary motoric ability to fight or flee with or for her offspring: a fact familiar to ethologists, biologists, physiologists and psychoanalysts alike. Engel (1954) has called our attention to the need for a new physiology to account for the early somatic concomitants of object relationships.⁵

The most striking and complete study in this respect is that of Spitz who, beginning in 1934, contributed so greatly to this field through his many articles, monographs, and films. In his book *No and Yes* (1957), he has described sequences of events in children deprived of human contacts which, in an exaggerated form, parallel what I observed and reconstructed in my case. To quote him: 'When alone and undisturbed, these children were quiet enough. They would *lie supine*;⁶ when they became active, their main activity consisted in bizarre finger movements. They would watch the movements of their fingers for prolonged periods, sometimes for hours. Headrolling, somewhat in the nature of *spasmus nutans*, was present in one isolated instance. Head-banging was not observed. They might clutch their garments and, as in forced

grasping, be unable to relinquish their grip, dragging the garment into the weirdly waving pattern of their hand activity. When particularly active, they would also lift their legs and clutch at their socks and toes. These few activities encompass all that these children suffering from hospitalism did. These activities occurred only, if at all, in the early stages of deprivation. Autoerotic activities, including thumb-sucking, were practically non-existent. In the more advanced stages these children *would sink into lethargy*,⁷ *lying without movement or sound, staring into space as if in a daze*.⁷ The approach of anyone, outside that of the nurses at the hour of feeding, evoked manifest unpleasure.'

Admittedly, the correlation of these early physiological reactions, occurring at a preverbal stage in the development of humans, is most difficult, and what Spitz described refers not only to an earlier period of life but also to an extreme reaction which may not be fully applicable to my patient. She seemed to have acted in a similar fashion to these mother-deprived children for what were, in all probability, short periods of time while taking a nap, or when left alone in her room, or when falling asleep at night. She lived in a very large house and in infancy and early childhood was most of the time alone in a large room, sometimes on a different floor from her parents or grandparents. However, there could be no question about the fact that for those short periods of time her reactions had much in common with those described by Spitz.

What I wish to stress here is that the infant, with its obvious inability to fight or flee, and not yet possessed of the necessary mental abilities for the formation of a stimulus barrier, can only react in the way Ernest Jones described in his paper on 'Fear, Guilt and Hate' (1929). He named that type of mechanism 'aphanesis', in keeping with the concept of libido as the sole source of energy. In this contribution, which has been ignored much too long in the psychoanalytic literature, Jones assumes that the only defence against intolerable frustration or stimulation is violent crying and diffuse and extreme motoric movements. Since this reaction is useless in the absence of a mothering figure, the only possible limit or regulation under such conditions is continuous discharge of energy until complete exhaustion is reached. This leads to loss of

⁵ Quite a number of authors have significantly contributed in this area. To cite a very few, one must mention: I. A. Mirsky's studies of pepsinogen levels in infants (1960), Benedek (1956), Mahler (1952), M. Ribble (1946),

Escalona (Bergmann and Escalona, 1949) who studied infants and their relationships to early objects.

⁶ Italics mine.

⁷ Italics mine.

consciousness, or a mixture of slumber and loss of consciousness, which temporarily relieves the tension by making the organism impervious to stimulation (Burton and Derbyshire, 1958). This kind of sleep of exhaustion must be most unpleasant, yet welcome, if it shuts off further stimuli. Only in this way can sleep become a defence mechanism since, in the absence of those intolerable frustrations, sleep is only a pleasant stage following satiation at the breast, and longed for because of its pleasantness. Freud, in *The Interpretation of Dreams*, implied that sleep is the prototype of all defence mechanisms, and Spitz assumes that he reiterated this belief in the *Three Essays on Sexuality*⁸ (1905). It is not far-fetched then to assume that sleep, a pleasurable part of the withdrawal mechanism, might serve as a combination of gratification and defence when under the impact of unmanageable stimuli leading to exhaustion, it is physiologically thrust upon the infant as the only way out of an insoluble situation. Recently, Bergmann and Escalona (1949) have called our attention to existing differences in threshold at birth and emphasized what happens to the development of the infant's ego under circumstances of passive helplessness against external stimuli. Rapaport relates the development of passivity to similar unusual or intensive stimuli from which the organism cannot actively withdraw (1953). As soon as the infant develops any ability to defend itself against intolerable stimuli, withdrawal or regression into sleep can become an active defence rather than a passive experience. Kris also assumed that sleep was the forerunner of his concept of regression in the service of the ego (1952a).

Engel and Reichsmann (1956) in their analysis and film of Monica W. demonstrated how she withdrew into sleep when confronted by a stranger. I myself witnessed this phenomenon repeatedly when I observed Monica in Rochester behind a one-way screen. As she improved she gradually accepted some strangers without withdrawing.

They describe the process as occurring in a series of steps: (1) sudden hypotonia and turning away with occasional looks; (2) increased immobility with flashes of irritability; (3) total immobility leading to sleep; (4) restitution during sleep; (5) return to step (3) if stranger were still present on awakening.

It is interesting to note how similar these steps are with what my patient experienced or remembered on the couch. As Monica grew older these steps became more discreet and blurred. The fact that they could be seen so clearly in my patient almost in their pristine form as they occurred in childhood is no doubt related to the use of a somatic expression of her unconscious conflicts (Barchilon and Engel, 1952). There are many points in which the observations and assumptions made by Engel and his co-workers and my own overlap, coincide, or confirm each other. Since the data were obtained by two very different methods, direct observation in one case and psycho-analysis in the other, I believe that we validate each other. For example, Engel also described two kinds of sleep in Monica of which only one permitted 'recathexis and some restitution'. We must assume that my patient's 'black sleep' had failed to shut off psychic stimuli completely and did not permit what Engel calls recathexis (Engel *et al.*, 1956).

Spitz, commenting on the same Monica, stressed the fact that sleep was her main mechanism for withdrawal. Bertram Lewin (1950) pioneered in emphasizing essentially the same thesis in his brilliant formulations of elation and the oral triad: 'To eat, to be eaten, to sleep (to die).' It is strange that sleep has been understood in all these descriptions given by psycho-analysts only as a psychological phenomenon. Its physiological basis and meaning have been largely ignored. The extraordinary physiological changes leading to death in the cases described by Spitz in his article and film on hospitalism have not attracted the attention of the neurophysiologists. Yet here is a defence mechanism of extreme importance to human beings, and probably to other altricial animals, which combines physiology and the earliest psychological reactions very intimately. It might even be, in the area of behaviour, the only mechanism available to the infant to restore its equilibrium or defend itself without the help of the mother.

III. Further Clinical Material from the Analysis and Experimental Evidence

Returning to my patient, she and I came to call this mechanism the *possum defence* because, like the opossum, she could neither fight nor flee but remained motionless, actionless, and was not

⁸ This is equally true about dreams. They are a combination of defence and gratification since they are like a hallucinatory wish fulfilment which also protects the

sleeper against any awareness of the process which might awaken him (Freud, 1900).

even scared. I made one isolated interesting physiological observation at this stage of her analysis. As she was reliving on the couch the first episode of her possum defence where she felt that *nothing* could be done ever, that *nothing* should be done, when tears were rolling down her cheeks and she was feeling all the unpleasant sensations which I described earlier, I assumed that she might be terrified and that her heart rate and respiration would be fast. However, she was breathing *less than ten times per minute* and her pulse, which usually beat at 78, was *down to 62*. This was in marked contrast to occasions when she expressed resentment or sexual feelings, at which times her respiration would go up to 25 per minute, and her pulse to 120 or more. (I happen to have a rubber pillow on my couch and with some patients have learned to count the pulse by the bobbing of the head on the pillow.) This is certainly different physiologically from the usual fight or flight patterns. Monica too showed decreased respiratory and heart rates (Engel *et al.*, 1954). Reiser, in his Presidential Address to the American Psychosomatic Society, cites the case of a 30-year-old healthy physician who fell asleep on a ballistocardiographic table and had a nightmare from which he woke up with all the symptoms of severe anxiety, including palpitations. 'Yet the record of blood-pressure, heart rate and ballistocardiogram showed *no change whatsoever*.' Reiser asks, 'Where did his physiological reactivity go?' My hunch is that, as in my patient, it was a reactivity of sleep, not of waking life. In the conclusion of the same paper he states: 'The data—both clinical and experimental—resist interpretation by linear stimulus-response models of the simple or multiple factor type. Perhaps we are at a stage where formulations of the problem have to be more complex before new insight and understanding will provide fresh clarity. Though the truth once fully out is usually simple, simplicity itself carries no special virtue in the search for knowledge. This may be a time for further experimentation with methods, and for struggle with uncomfortable conglomerations of ideas in an attempt to deal with a variety of phenomena that so far defy clear ordering of the data' (Reiser, 1961).

This system of defence is similar to that of elation as formulated by B. Lewin, since it permits the partial gratification of an instinctual need, and the compulsion to repeat the defence means also a compulsion to repeat the gratification. This patient does not only fall partly asleep

or use a sleep equivalent, but she also is symbolically fed, gets the breast to herself, and is being eaten. In one of her sessions she stated the following: she was anxious and waited in the car before coming to my office. As soon as she lay down, she complained that the couch was too far from the wall—the cleaning woman had pushed the couch some two inches away from its usual position. The patient thought that she had too much elbow room. She became anxious again and felt a tightness in her chest. She thought of herself as a small child in mother's arms, with her left arm squeezed against mother's belly. She remembered being afraid to sleep in a bed too close to the wall because a spider might come down the wall and bite her. She thought of a monstrous spider, then she related how that fear would make her put a soft pillow over her face for protection. This would smother her, so she would raise the pillow for a breath and put it back on her face and keep repeating this manoeuvre until she felt a tightness in her chest and fell asleep exhausted and alone. She was never afraid if one of her sisters was in the room with her. As she was struggling with these memories, she related them to her choking sensations and nausea when, a year earlier in analysis, she thought of swallowing a grapefruit seed and feared, as her father had told her in jest, that a tree would grow and come out of her mouth. She had previously equated this grapefruit seed with swallowing a piece of faeces or his penis. Following this a verse from a rhyme came into her head. It was about the old lady who swallowed a spider. The next day she corrected herself and said what she really meant was a nursery rhyme from much earlier in her childhood.

Little Miss Muffet
Sat on a tuffet
Eating her curds and whey.
There came a big spider
Who sat down beside her
And frightened Miss Muffet away.

For many months the patient had spoken without affect of her mother's breasts as being large and very soft. After remembering how she smothered herself with a pillow, the thought of mother's soft breast nauseated her. The identification with Miss Muffet, the curds and whey as components of milk, and the big spider as the mother who was beside her, are self-evident and did not escape the patient's attention. What was more interesting was that apparently

the wall next to the couch had had for her the meaning of mother's breast⁹ for quite a while, and had remained unverbilized because of her ambivalent feelings towards the breast. Her arm falling asleep stood for herself falling asleep, eating, and being eaten, as well as a defence against clutching and tearing the breast with her hands. Of late she had been sleeping on her left hand, and the preceding night she had slept prone on both her hands.

As these reactions were understood and worked through the patient became aware of repressed sexual strivings towards her mother and, interestingly enough, her reaction to frustration in this area was handled not by hypotonia but by muscle contractions in the left as well as right side of her body. She described some of these new feelings as follows: she had stopped using any contraceptive precautions for a year or so and had been pregnant for about two weeks when she had a dream in which she got sexually excited while in the company of a brother-in-law. She went to the bathroom in order to masturbate when she noticed that she had a large erect penis. But mother, and maybe Susan, her sister, were in the bathroom already, and she felt that she would lose her erection since she could not get into the bathroom. This dream was thoroughly interpreted. In the following hour she said, 'I cannot tell what I am feeling. It is as if I were menstruating, yet I know I am not. It is strange, but I have had to remind myself to breathe last night and again today on a number of occasions, but I am not panicky or really scared. In fact, most of the time I am kind of proud. I thought a lot about yesterday's dream. Father would not have me, so I needed a penis to love mother. But why are my left hand and arm tense, like when I was angry at father, or is it that I can now deal with her as I do with father?'¹⁰ When I think that she did not love me either, I hate her and tense up. I feel like laughing (she smiled), but I don't want to because I still owe her too much hate. Strange, this is the opposite of my choking, smothering, sleepy feeling.' Motor activity was now possible, but partly at least by identification with the aggressive phallic mother. She stood up to her not so much as a pregnant woman but rather as a phallic lover and rival.

IV. Second Discussion: General Considerations on Psychosomatic Disorders

These observations suggest many tempting speculations on the roots of masochism and the death instinct which can be only touched upon here. This patient with rheumatoid arthritis illustrated in a small circumscribed area of her psyche and soma a type of mechanism having mostly to do with withdrawal into sleep. This mechanism must be considerably more prevalent than has been heretofore assumed in the psychoses as well as in the psychosomatic disorders. Sleep equivalents play a part in hypomania and many schizophrenics fall asleep, become catatonic, or hallucinate as a defence against threatening drives. The fact that anger at mother did not frighten this woman, did not sadden her, and did not make her want to fight, was possible only because she could partially turn herself into an *opossum* at the motor level. Because it is so colourful and descriptive a word, but also because I have a hunch that it is physiologically related to that animal, I would like to suggest continuing to call this mechanism the *possum* defence.

In general what I have described here is consonant with Engel's depression-withdrawal entity and E. Bibring's formulation of depression as a basic mechanism (Bibring, 1953). But I view the mechanism and affects involved from a somewhat different point of view. I am sure that 'depression-withdrawal' takes place much as Engel describes, and that his concept has great theoretical value, just as the concept of aphanesis does; but it defines only one end of the spectrum. It seems to me that it does not account for all the observable phenomena in cases where the early traumatic deficiency in the infant-mother unit has not been severe enough to hinder further development and life, albeit a life constricted by neurotic, psychotic, or somatic symptoms. It may be that Engel, for the sake of clarity, intends to emphasize only the unpleasurable end of the affective spectrum just as Jones and Bibring did. Therefore, I find myself closer to Spitz, Ribble and B. Lewin in trying to reconstruct and describe these phenomena. For example, Ribble (1946), writing about baby Pat, says: 'The only sure means of gratification for this infant was sleep which was

⁹ Dr Joseph Coltrera uses a couch situated in the middle of his office and told me that his patients often feel anxious without the protective proximity of the wall. He, too, traced this anxiety to the equation of wall and breast. (Personal communication.)

¹⁰ Dr Nydes told me that one of his patients suffering from vaginismus kept thinking during intercourse that she wished so much to be penetrated. She lost her vaginismus only when she learned to think: I am afraid, I hate to be penetrated. (Personal communication.)

not actually sleep but really an automatic withdrawal. This economy of function enabled her to maintain life by a sort of hibernation and the interruption of this protective mechanism filled her with uncontrollable anxiety.' In this description, withdrawal is neither pleasurable nor unpleasurable; if anything, it seems to be the only pleasant experience of baby Pat, since it is one of her only means of gratification.

I see little or no room for this pleasurable element in Engel's formulation. In fact he considers the affect of withdrawal a pure and primary affect, as indicated by the title of his paper (1962a), 'Anxiety and Depression Withdrawal: The Primary Affects of Unpleasure'. From a theoretical point of view, I would like to propose the following alternative:

(1) The type of mechanism described by all of us should be called 'primary withdrawal', 'aphanisis', mostly for historical reasons or 'conservation withdrawal', an apt descriptive expression coined by Engel (1962a).

(2) The affect which accompanies it may or may not be a primary and elemental affect. Since affects are determined by the outcome and what happens after a mechanism is used, it is usually unpleasant but is seldom if ever wholly so. More often, it is a mixture (in varying proportions) of pleasure and unpleasure. This is certainly the case for baby Pat and for my patient, both of whom enjoyed being able to shut off unpleasant stimuli. Moreover, Engel and Bibring's terminology implies that the affect of 'basic depression' and 'depression withdrawal' is the anlage of later life depressions. Neither of them really meant that implication, but it has become part and parcel of the word depression because of its clinical usage sometimes to designate a mechanism and sometimes an affect. I think it desirable to clarify this semantic confusion since it is clear to Engel as well as Bibring that this primary mechanism and its accompanying affect are basic to many more reactions than just clinical depressions. It may be that Jones sensed this problem and was right when he proposed a new word for this mechanism. In that case we could use other new names such as Bradybiosis or Bradyphylaxis,¹¹ which would be more in keeping with the notion of life processes and vigilance being lowered and slowed down. These words would free us from the affective connotations implicit in depression as well as the idea

of absence of libidinal energy explicit in the word aphanisis. They would also permit us to categorize, at the other end of the life spectrum, processes such as anxiety which tend to quicken life and vigilance as being Tachybiotic or Tachyphylactic.¹² While there is little doubt about the general validity of this idea, one must not forget that neurotic and psychotic depressions contain elements of activity (as opposed to passivity) (Rapaport, 1953), which are very different from what is observed in the infantile reactions which we are examining. Even if 'depression withdrawal' turned out to be a basic mechanism in the depressive syndrome, I would be inclined to be more tentative at this stage of our knowledge, because I do not think that we truly understand what the affect of primary withdrawal might be. It seems to me closer to a kind of affective indifference or *neutrality* accompanying hibernation and the desire to *do nothing*, giving up, or not caring. While it could be related to depression, it is much more likely to be the anlage of the affect of boredom and apathy (Greenson, 1951) than that of grief, sadness, and clinical depression.

This affective neutrality, if it were demonstrated, could be due to a decrease in energy distribution in the mental apparatus, especially an alteration of the state of consciousness and attention cathexis such as occur naturally in sleep.¹² On the other hand, the pleasurable element which I have re-emphasized could have great theoretical value, for the following reasons:

(1) It reaffirms the presence of positive elements in homeostatic states compatible with life (this may be a truism but it is often lost sight of). Except in extreme cases and for short periods of time, symptoms and mechanisms tending to restore equilibrium do not develop exclusively for defensive needs (for negative reasons so to speak). They must have adaptive value and therefore be in some way pleasurable. It is curious how these well-known principles are overlooked and how pleasure is so de-emphasized at the expense of unpleasure in dynamic descriptions of symptoms and reactions. In the last few years Lechat (1957) has been calling our attention to an important and usually overlooked role of the mature superego, that of regulating and insuring the flow of pleasurable supplies. Pleasure is a necessary affect without which the ego cannot develop, and the prolonged constant

¹¹ These new Greek words were suggested by Dr Bennett Simon, who reminded me that phylaxis originally meant a protecting, guarding vigilance.

¹² Cf. the altered states of consciousness exhibited by my patient prior to and while reliving her past episodes of withdrawal.

absence of pleasure in direct or disguised form is incompatible with life. Freud (1920) stated the same idea essentially when he mentioned that the reality principle is nothing but a modification of the pleasure principle. Hartmann (1939) developed this theme much further, and according to Loewenstein (1957), suggested the possibility that both the pleasure and reality principles are 'subordinated to a reality principle in a wider sense'.

(2) Returning to the possibility that the affect of withdrawal might be a state of affective neutrality, it is possible to conceive of this neutrality, at least theoretically, as being also produced by some equilibrium between pleasure and unpleasure.

Changes in proportions of the affective mixture could have much to do with developments in the ego. The presence of this pleasurable element might shed some light on that obscure problem of *how* a given human being develops a depression, a masochistic, a psychotic, or a somatic reaction. We must not forget that Freud postulated a death instinct to explain clinical observations about longing to kill one's self, to suffer, or to die blissfully, and anyone who has analysed schizophrenics or patients with psychosomatic illnesses can readily confirm those observations. This is not the place to discuss the validity of a death instinct but, if we concern ourselves exclusively with the wish to die, we find that it is always equated with sleep, and death acquires its pleasurable, longed-for quality from that equation. In that instance the compulsion to repeat a defence, be it somatic or psychological, acquires a fuller and more comprehensible meaning (since in addition to the guilt elements, the unconscious wish to master, a symbolic return of the repressed and other principles which guide the need to repeat, the compulsion to repeat is also the compulsion to seek a gratification). Freud regarded the compulsion to repeat as applying to both pleasurable and unpleasurable experiences (1920). The mixture of pleasure and unpleasure derived from shutting off unpleasant stimuli because of similarity with sleep and the oral triad of B. Lewin easily lends itself to secondary erotization and could explain much of what Freud attributed to the death instinct.

Lastly, I would like to reiterate that the wish to die is quite different from the wish to kill one's self, as pointed out by E. Bibring (1953). The latter is an *active* process involving aggression in some measure, and is usually seen as a

concomitant of the depressions. In contrast, the former is a passive longing, usually accompanied affectively by feelings of emptiness and boredom, helplessness, apathy, hopelessness and being at the mercy of circumstances and objects. Even the feeling of being boring to others is curiously devoid of aggressive qualities, as Reider (1951) described so accurately.

In most cases this psychological state is linked in one way or another with unusual physiological manifestations related to catastrophic and archaic emergency reactions leading to physiological collapse and death. This is what Walter Cannon described in 'Voodoo Death' (1942) and was elaborated upon in more detail by C. P. Richter in 'Sudden Death in Rats' (1957). Richter described how wild rats, forced to swim under unfamiliar and seemingly *hopeless* circumstances, give up and die without a fight. Their heart rate and respiration are slowed down, and cardiac arrest occurs in diastole. He attributed this reaction to a vagal, parasympathetic effect quite different from what occurs in fight or flight sympathetic reactions. Interestingly enough, if a rat which was on the verge of giving up and dying were fished out and allowed to rest for a while, and then subjected to the same experiment, it would now fight and swim for hours. Richter postulates that the rat had now acquired experientially a reason for *hope*. John Lilly (1960) possibly described a similar phenomenon in monkeys in his paper on 'The Psychophysiological Basis for Two Kinds of Instincts'. I have attempted to show elsewhere how some parts of these extreme physiological reactions are preserved in some of the psychosomatic illnesses and can reappear in attenuated forms (1963). The patient described at length in this paper showed relative bradycardia, hypotonia, and a diminished respiratory rate. These reactions were difficult to understand and trace back to their anlagen. Many authors have recently concerned themselves with other types of unaccountable physiological reactions (Green *et al.*, 1956; Reiser, 1961; Schmale, 1958). Yet once I related the mechanisms involved to sleep, a whole dimension was added to my formulations.

This new layer among the many that played a part in my patient's symptomatology could be seen in many places. For example, her frigidity did not yield to the usual interpretation that an orgasm was equated with death; this did not reassure her. When she finally experienced her first vaginal orgasm, my expectations that this

would be an intense experience (never again to be experienced with such violence), a mixture of horror, impending death and supreme bliss, was fully justified. The same combination of hate and love, desire to be united with a love object and wish to kill it, were condensed in a colourful expression which she invented for my benefit. She would say, 'Oh, go to heaven!', meaning drop dead but in a place where you and I can reunite. As will be remembered her 'white sleep' was equated with heaven.

This evidence may not seem convincing to everyone, because in many ways we are dealing with complex, multi-determined, and distorted derivatives. Yet more recently two other hysterical patients clearly demonstrated to me in a scarcely distorted way the prevalence of these factors in their physiological reactions. One of them, a woman of 29, given to escaping conflicts by entering into mild dissociated states and becoming amnesic, had the following reaction when I interrupted her analysis for four days after only three months of treatment. She was taken to a hospital by an internist because of alternating constrictions and vaso-dilatations of the blood-vessels of her hands and forearms. For two days and a night her upper extremities remained markedly hypothermic and nothing could warm them up. When I came back she kept asking me: 'If you don't care for me, what have I got to live for? . . . I know I can let myself

die. . . . It started in my arms. . . . I could have let it go further and further. . . . I always wondered if I could will myself to die. . . . I know now it can be done. . . . ' To counteract this type of reaction, this woman relied on exciting self-destructive acting out, and was addicted to perilous sexual situations. These made her feel alive, awake, and tingling for a while, but they would quickly lose this quality, and she would then feel bored and uninterested, except that she was afraid of fainting unexpectedly.

The other patient revealed incidentally that she had a basal metabolic rate of minus 39 for which no cause could be found. Her only pleasure was a dreamless sleep, of which she seemed to require ten hours a night. This woman was a shame-driven character who had lost her ability to blush. After three months of treatment she refused to look at me and literally stopped looking in my direction. After one year of analysis she started to blush and to dream, and had great difficulties in falling asleep. Her metabolic rate, which was checked several times by a doting family doctor, registered minus 10 for the first time in many years.

These observations would have puzzled me in the past. Now that I had been sensitized to their possible physiological and psychological meaning, I was alerted and in fact helped to look in a direction which I might otherwise have neglected.

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COLDS AND RESPIRATORY INTROJECTION¹

By

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The paradoxical use of the word 'cold' for what is really an afebrile or slightly febrile condition, has been examined in other languages. It was primarily related to 'catching cold' from draughts, etc., or to 'dripping'. In the Indo-European languages, the roots were Greek or Latin; from the Greek *Katarrhos*, *koryza*, and *rheuma*, all of which referred directly to flowing, though indirectly to tears. From the Latin: *destillatio* was a dripping, and *perfrictio* 'catching cold' and 'violent cold'. Interestingly, another Latin synonym was *gravedo*, which meant heaviness of the limbs, cold in the head. This word also meant pregnancy in popular speech, and was so used by Nemesianus, a didactic poet of the third century A.D.

The word 'cold' itself has many secondary meanings; the feeling of the loss of bodily warmth related to physical separation; the idea of separation as expressed spatially, i.e. cold = distant; and with the absence of emotional warmth.

Closely associated to the term for 'cold' are the ideas of birth (*gravedo*) and death (the Portuguese word for 'sneeze' is *espirrar*, with the association of 'breathing out' meaning 'to die'), as well as sadness and tears. In addition, the word *destillatio*, as pointed out by Havelock Ellis, also came to mean a slight urethral discharge following sexual excitement and prior to orgasm.

Frequent studies have ascribed a definite viral aetiology to colds or cold equivalents. Colds are not uncommon at birth, when the respiratory passage is blocked with mucus. Obstetricians have reported hearing the neonate sneeze during the birth process. The writer has observed a cold, or catarrh, in a female neonate, developing immediately after birth, and lasting for at least three weeks. There was no possibility of its being an infection requiring any incubation period, as the mother had been cold-free for a considerable time prior to the birth. There was

a high level of maternal hormone, as the baby's breasts were engorged and she menstruated slightly after birth. The cold may have been a somatic response to the external or internal (hormonal) environment.

Goldstein (1951) relates the following conditions to the common cold: 'acute respiratory disease (the term disease is used in order to suggest biochemical disequilibrium rather than infection, which implies specific injury resultant from bacterial invasion and tissue destruction); twenty-four to forty-eight-hour fever; acute G-I disease characterized by recurrent abdominal pain; vomiting and/or diarrhoea. Under respiratory disease were grouped coryza, croup, acute pharyngitis, acute laryngitis, acute tracheitis, and acute tracheobronchitis.' Goldstein makes a categorization, 'the common cold, cold equivalent (gastro-intestinal dysfunction), or grippé—all of which are merely different forms of the same acute manifestation of disease'.

In this paper, however, the term 'cold' is used mainly for that syndrome, classically called coryza or nasal catarrh, with primarily upper respiratory tract symptoms sometimes associated with nausea and loss of appetite.

Goldstein concludes from his study that grippé is a syndrome precipitated by stress factors as well as by infectious agents, and that the body reacts to cold as it would to any severe stress situation.

The role of infectious agents will not be discussed here. However, it is known that the human organism may harbour these agents at all times, and only under specific circumstances will this benign symbiosis flare up into an overt 'infection'. Some of these circumstances have been investigated.

Holmes and others (Wolff *et al.*, 1950) have discussed many functions and reactions of the nose, except the olfactory one. 'Other investigators have related the occurrence of sinusitis in children, and of recurrent colds in adults, to the

¹ Revision of a paper originally presented to the Canadian Psychoanalytic Society, 17 February, 1955.

nasal hyperaemia and obstruction which accompanies emotional conflict in insecure life situations.'

Under various stimuli which they called 'specific threats' to the respiratory apparatus, they observed alterations in nasal functions and a pattern of reaction to irritants which appeared to have biological significance, 'attempts to shut out and wash away the offensive agent by the closing of the eyes, nose, and upper airways and by lacrymation and rhinorrhoea'. There was hyperaemia, hypersecretion, and obstruction in the nose, but the period of reaction following these stimuli was not much more than one hour. None of these stimuli, then, produced a cold. It was found, however, that under specific emotional stresses, which they call threats to emotional integrity, catarrh-like conditions were produced, lasting for a considerable time and resembling the common cold. Their findings resulted in the concept that the cold acted as a 'shutting out' mechanism.

Freud first referred to a catarrh in the Dora case (Freud, 1905). He described Dora's catarrhal identification with the mother and an upward displacement of what came to be a post-nasal discharge. The concept of respiratory incorporation is one of the important determinants of Dora's asthma, the explanation given by Freud no doubt not exhausting the over-determination.

Karl Menninger (1934) interpreted the cold as a symbolic punishment for castration tendencies: 'her cold thus would seem to be a re-enactment of her wish to castrate her brother and acquire his penis—the acquisition of a symbolic penis in the form of a conversion symptom, combined with punishment at the same site, and finally the renunciation of this wish in favour of the feminine receptive attitude, masochistically symbolized, the whole theme being transposed from the genital region to the respiratory tract and represented somatically.'

Saul (1938) mentions in his cases 'strong receptive demands frustrated, swelling to a rage at the thwarting, caused coryza, mild depression and nausea, constipation, headaches and fatigue'. Associated with the sore throat and coryza in some of his female patients was a vaginitis and leucorrhoea. Saul associates this with unconscious weeping reactions. He questions the role of repressed anger and hostility as not being too clear, but he notes that during this phase in their analysis there was increased

activity in the oral region, 'such as swallowing, mouth breathing, biting and teeth grinding, and these activities result in soreness of the throat, abrasions of the cheeks and sore gums and jaw joints'.

He also states that 'nasal catarrhal secretion appeared regularly in periods of unsatisfied receptive demands—it appeared only at those periods, and disappeared when the analysis made the emotions more fully conscious'.

In attempting to define the relations between specific emotions and the catarrhal secretion, Saul lists three factors:

(1) The similarity of the mucosae and the presence of erectile tissue in both the genital and nasal regions, and the physiological function of catarrhal secretion as a lubricant.

(2) Eliminating impulses; diarrhoea and constipation, transitory urinary urgency.

(3) Association of nasal catarrh with lacrimation and more particularly from the continual swallowing of post-nasal discharge and tears associated with the idea 'Since I cannot get what I want from others, I must give it to myself'.

Saul suggests that coryza may have a self-consolatory, self-feeding, self-pitying function. 'Some of the material suggests coryza may be in part a disease reaction against unacceptable, more or less masochistic, unconscious receptive wishes or fantasies.'

In the aforementioned papers, respiratory function and olfaction are not mentioned at all in discussing 'colds'. It was Krapf (1956) who first related colds, separation, and 'a need for "respiratory introjection"—closely related to oral introjection'.

The first description of respiratory incorporation occurs in Freud's paper, 'From the History of an Infantile Neurosis' (1918).

The Wolf Man's obsessional rituals spread to breathing; 'Each time he made the sign of the cross he was obliged to breathe in deeply or to exhale forcibly. In his native tongue "breath" is the same word as "spirit"... He was obliged to breathe in the Holy Spirit, or to breathe out the evil spirits which he had heard and read about... He was... also obliged to exhale when he saw beggars or cripples, or ugly, old, or wretched-looking people; but he could think of no way of connecting this obsession with the spirits. The only account he could give to himself was that he did it so as not to become like such people.'

Freud states that the heavy breathing was an imitation of the noise which he had heard coming

from his father during coitus and describes how from an early age the patient suffered from attacks of malaria which, 'in the patient's dreams during the treatment was replaced by a violent wind'. The child finally interrupted the parents' intercourse by passing a stool which gave him an excuse for screaming. Here we might hazard the speculation that one of the noises heard during coitus was flatus and that the passing of the stool was accompanied by flatus. In other dreams a 'tutor' in the shape of a lion came towards his bed roaring loudly. Freud saw some connexion between breathing rituals and faeces (although in this paper he does not mention flatus or sense of smell) because after talking about the patient's obsession of having to think of the Holy Trinity whenever he saw three heaps of horse dung or other excrement lying in the road, Freud immediately goes on to describe the breathing rituals as part of the obsessional defences.

Ruth Mack Brunswick (1928), in her continuation of the Analysis of the Wolf Man, discusses the hypochondriacal preoccupation with the nose, but does not relate this at all in her paper to the sense of smell or respiratory incorporation. She does, however, give us further clinical hints: the patient's mother was afraid of draughts, disease, and infections of all kinds. At the age of puberty a nasal catarrh had caused sores on his nose and upper lip requiring salves for their treatment, and he later had another catarrh, namely the gonorrhoeal. She refers to the patient's frequent bronchitis, fear of catching cold, and fear that an influenza would develop into pneumonia. She does note that the patient 'had a nasal catarrh which proved very resistant to treatment. Coming at puberty it was probably psychogenic'. She states that the cause of an early period of seclusiveness and misery was an acute nasal infection.

Fenichel (1931) reports a case which began to behave exactly as did the Wolf Man in his second illness. Fenichel added that the penis and nose hypochondria were related to a partial incorporation and narcissistic identification, the equation nose = penis = introjected mother. The mother was introjected with the following fantasy: 'I have smelled faeces and thereby my mother has got into my nose.' The patient conceived of his mother's soul or spirit as breath which he had inhaled = smelled. Fenichel uncovered fantasies about fatal smells or breath. He detailed the relationship of respiratory incorporation to oral introjection. 'The

idea of incorporating an object by breathing or smelling it is the expression of a particular sexualization of the respiratory and olfactory function. The desire to smell has often been connected to anal erotism in accordance with its most outstanding object . . . not quite rightly, because its excitations reside not in the rectum but in the nose.' He assumed that there is an autonomous respiratory erotism which, though not intense in itself, gains importance through the displacement of quantities of oral and anal energy on to it. This respiratory erotism has an archaic pregenital character.

In the case of the Wolf Man, we might guess that the conflict over respiratory incorporation, the preoccupation with the Holy Spirit, as well as the dreams of the roaring lion and violent wind, might all be related to a not uncovered preoccupation with fantasies involving the smelling of flatus which was symptomatized by the nasal catarrh.

Saul suggested that the cold was a disease reaction against unacceptable masochistic receptive fantasies. Weiss (1922) described a case of asthma in which the illness set in as a reaction to the loss of the mother and to a subsequent narcissistic identification with her, the asthma being related to attempts to incorporate the lost mother. In the present paper it was surmised that the nasal catarrh was related to conflict involving respiratory introjection.

Fenichel pointed the way to understanding certain hitherto unexplained aspects of the nasal symptoms. In a paper, 'Fear of the Dead' (1922), he reports a case of a psychotic woman hallucinating fearsome ghosts, who fantasied that she became pregnant by incorporating a steam-like mass ejected by devil-animals or ghosts (symbolizing the father). Fenichel (1945) states that the function of breathing has been treated by psycho-analysis in a step-motherly way. Breath is the first introject. Birth is the first experience of a new environment and, as Freud showed, results in prototypical anxiety as a response to overwhelming stimuli.

Certainly birth is the first great move or separation, and clinically, the cocoon-like feeling (withdrawal of object libido) experienced during a cold seems unconsciously associated with intra-uterine fantasies, probably as a regressive defence against object loss. The closely allied fantasies around life and death are mobilized by any object loss.

Since colds are a respiratory disease, it might help to discuss how the ideas of life and death

and the human soul might be related to air and breathing.

Jones (1914, 1923a) gives an elaborate discussion of the idea of the genesis of the soul from the breath and flatus. The idea that the soul—ghost is derived from breath and flatus is not only found in primitives but is the basis of the Greek 'pneuma'. 'Aristotle, for example, states that the pneuma of the body . . . is not derived from the breath but is a secretion resulting from processes going on within the body itself (primarily in the intestines), and Galen says, even more explicitly, that the psychic pneuma is derived in part from the vapours of digested food. The world-wide belief that the soul escapes through the mouth probably refers . . . to ideas concerning not only the respiratory system but the alimentary one also.'

In the Hindu Vedas the air is divided into nine Paranas. One of the paranas, the Udana, 'which denotes gas regurgitated from a flatulent stomach, is an interesting counterpart of the apana, for while the latter is formally identified with death itself, the former carries away the soul from the body after death'.

Both Fenichel and Greenacre (1951) discuss in their papers on respiratory incorporation the elaboration of fantasies concerning flatus, breath, and the soul. Anthropologically, there are some interesting rituals or defences used to ward off ghosts which are germane to this subject.

Sir James Frazer (1933) refers to numerous rituals used by primitive peoples to ward off the ghosts of the recent dead, and associated with this, the common hope that the spirits will ultimately be reborn in the infants of the family.

Jones points out the frequency with which loud noises 'were considered especially effective as apotropaic measures against the malign influences of evil demons. By the side of this, Luther's statement may be recalled, according to which the Devil is to be driven away through the efficacy of the passage of flatus'.

Antipathetic magic is to be seen in the widespread observances during a funeral that no careless noise may be made, for this would excite the anger of the ghost, who would take revenge on the survivors who show so little regard for his feelings.

In the Banks Islands, the belief that the spirit of the deceased remains to haunt the neighbourhood for four or five days leads the natives to attempt to drive it away with shouts, the blowing of conches, and the bellowing sound of the bull

roarers. Similarly the Fiji Islanders, in British New Guinea the Kiwai, and the Ewe-speaking people of Togo in West Africa attempt to drive away ghosts by making noises.

At Western funerals there is lavish use of flowers and incense, possibly to cover odours.

The belief that all spirits are highly sensitive to smells, among the Mangars, one of the fighting tribes of Nepal, leads to the following ritual: one by one, mourners must pass through smoke coming from a pot of burning incense held by one of their number. Similar ritual fumigations were practised throughout Africa, among the Canadian Algonquins, the American Hidatsa Indians, and the Sacramento Indians in South America.

Mourners among the Kiwai, especially those who have carried the dead body, spit ginger over their hands and afterwards rub them with a sweet smelling herb, smearing their face and body with clay which is renewed from time to time. The Thompson Indians of British Columbia use tobacco and juniper and fresh fir boughs in the house of the dead man during the funeral.

Jones (1914) states, 'On the homoeopathic principle of "like repelling like", odoriferous substances have been used extensively to counteract unpleasant or dangerous influences.' In Greece, according to Heidel, 'exhaling effluvia of various kinds were the chief apotropaic and purificatory means employed in the most diverse circumstances'. Heat and cold were thought of essentially as effluvia, so that it is little wonder that fire became the apotropaic agency *par excellence* possessing the most evident emanations; that these were efficacious is testified by Plato's remark, 'The demons love not the reek of torches.'

Another defence against ghosts is in the plugging of body apertures: 'When the rain-maker is dead he is plugged, his mouth is plugged, he is plugged, his fingers are plugged. And then he is buried. It is done so that . . . the spirits may not go out . . .' (Frazer, 1933).

On the lower Yukon, below Ikogmut, 'the housemates of the deceased must remain in their accustomed places in the house the four days following the death, while the shade is believed to be still about. During this time all of them must keep fur hoods drawn over their heads to prevent the influence of the shade from entering their heads and killing them' (Frazer, 1933).

Among certain Eskimo tribes, members of the family involved in the burial stuff their nostrils with moss so as, they say, to prevent the invasion

of the ghost. This is quite obviously a defence against a smell and respiratory incorporation.

Oral incorporation and projection (ejection) is practised in West Africa in an attempt to exorcize the ghosts believed to cause illness: 'But to prevent the soul returning the animal must be ground to powder and swallowed by the sick man. When the man has swallowed it, digested it and voided it, they thought that he was finally rid of the tormenting ghost' (Frazer, 1933).

The idea of air as an impregnator comes most obviously to mind in the common expression 'I am inspired'. In Genesis, breath was life: 'And the Lord God formed man of the dust of the ground, and breathed into his nostrils the breath of life, and man became a living soul.'

Jones (1914) discussed childhood fantasies elaborated around wind and air: 'In their early cogitation about what is done by the father to bring about the production of a baby, many children originate the belief . . . that the mysterious act performed by the parents consists in the passage of gas from the father to the mother, just as other children imagine it to consist in the mutual passage of urine.' He lists a number of sources who state that conception was related to the wind. Among them are Aristotle, Pliny, St Augustine, and Virgil, and in Frazer there is considerable evidence of the significance of this idea in anthropology and folklore.

Jones believed that 'the idea of gaseous fertilization constitutes the reaction to an unusually intense castration phantasy' (1914, p. 350).

It is an old wives' tale that draughts and cold air and dampness cause colds. In an early paper, Jones recalled the frequency with which cold air was regarded as dangerous, having been blamed for such conditions as peritonitis, tuberculosis, pericarditis, pleuritis, and gastritis; and night air was blamed for malaria. 'It is interesting to note that cold air striking, like an enemy in one localized direction (draughts), is especially dangerous, notably if it strikes from behind' (1923b).

Case Material

In this paper, colds of apparently epidemic nature, where more than one member of the immediate family were affected, are not considered. An attempt is made to include only those single coryza-like conditions which seem related predominantly to two emotional stress situations. These stress situations were separations and losses, either actual or threatened.

The situations varied from actual separation of one person from another, to the varied separations from one environment to another, such as going on a trip, moving from one house or one city to another, holiday weekends, etc. The loss situations varied from an actual loss of a person, object, job, or income, to memorial mourning reactions.

In one case a complete shift in symptomatology was observed. A severely restricting agoraphobia was replaced by severe colds, occurring under the same circumstances that had previously elicited the agoraphobic and claustrophobic defences. In other cases a shift from cold reactions to overt neurotic depression was observed.

Following are some examples of colds which, superficially at least, were related to losses, separations, and mourning reactions.

Male patient, aged 40, who acted out continually, would arrange frequent so-called business trips to his home town, during which he would gratify many pregenital impulses. When this acting out was threatened with the alternative of discontinuing analysis or discontinuing these trips, the patient developed a severe cold immediately following cancellation of tickets for the projected trip.

Female patient, aged 28, developed a cold and severe cold sore following a separation from her mother who had gone on a trip. She felt extremely self-conscious and attempted to hide her mouth at all times. The analytic situation focused on frustrated oral trends. The cold sore cleared up immediately following the patient's acting out a restitution fantasy by giving her mother a beautiful new blouse.

Female patient, aged 28, with a cold following a week-end trip, spent the hour recalling moving from one city to another as a child, with frequent tears and coughs: 'My mother hated children and dragged them about with her from one town to another.' The patient discussed rebirth fantasies—she wants to walk out of the analytic hour and start a new life all over again—'so I could be nicer and kinder to people.'

Male patient, aged 35, during one analytic hour stated, 'All those theories and all the work about colds, loss and separation is wrong. Yesterday in the afternoon I developed a cold, one of the severest I have ever had, and I have not lost anything. There has been no

change in my life in the past week.' When it was suggested that maybe the date was important, the patient slapped his head with both hands and explained that it was a 'Jahrzeit'—it was the tenth anniversary of his father's death. This patient, in working through a repressed grief reaction over the father's death ten years previously, uncovered feelings of shame of his father, and developed diarrhoea, nausea, and signs and symptoms of a cold. This patient was extremely susceptible to smells and felt a very strong disgust at all anal functioning.

At another time he had attempted, successfully as he believed, to impregnate his mistress, who had stated she very much wanted a child by him. He came in with a cold and his only statement was that he had had intercourse the previous night. During his long silence the analyst stated that perhaps following the intercourse the mistress had menstruated. This the patient corroborated. 'Yes—the minute I saw the menstrual blood I said, "Jesus Christ, there goes my son."' The cold followed.

Male patient, aged 24, planning to go to New York to gratify impulsive homosexual drives, developed a severe cold just prior to leaving and regarded it as punishment for his bad wishes.

The same patient, after considerable analysis in which little cessation of the homosexual acting out was observed, was given the suggestion that rather than continue to discharge his anxiety by such acting out he should attempt to curb it and try to face some of the anxiety in the hope of analysing it. Immediately after leaving the analytic hour he went to a tavern, got drunk and picked up a bum in the street who had beaten him seriously a year previously. Immediately on acting out this feminine passive role, he developed a severe cold, went to bed, and missed the following two analytic hours. The suggestion was conceived by him as a masculine attack, exciting his feminine passive wishes, but the severe castration anxiety was displaced to his swollen, running nose which he associated with a urethritis which he regarded as a punishment for active phallic wishes. The running nose and illness allowed him to indulge in passive dependent acting out on his mother. It was also regarded as a punishment for the homosexual orgy, and the orgy itself, as well as the subsequent missing of two analytic

hours, were rebellious defences against submitting. Associated with feelings of being highly infectious was the reassuring fantasy, 'I am not impotent or castrated, my nose = penis still works.'

Male patient, aged 26, Eastern Mediterranean background, after a few months in analysis reported the sudden development of a cold the previous afternoon. He also reported a dream from the previous night. 'My mother and all her sisters were in your office making an awful fuss and racket.' When asked if he thought they might be mourning, he recalled that his maternal grandfather had died about a year ago. Further associations revealed that he had died exactly a year prior to the development of his cold the day before.

An Illustrative Session

The following is the record of one session with a patient complaining of severe depression, who had also frequent colds about which she did not complain. The patient began menstruating the evening before. She had got her first job in a strange city, having left a distant home to undertake analysis. The hour was characterized by frequent sniffs and coughs which are listed in the sequence in which they occurred, omitting the other material.

(1) Discussing girl friends leaving home—sniff and cough.

(2) 'At periods I could withdraw and for days would not see my friends'—sniff and cough.

(3) 'I can't stand women talking about nothing but their children'—sniff and cough.

(4) The patient coughed entering a silence during which she had been thinking of a boy friend who left without saying good-bye to her and she had felt hurt.

(5) 'Your window looks like a prison window'—sniff.

(6) 'I have moved into a room that is an awful mess and I need to clean it up'—sniff.

(7) At this point the patient noted that I was writing, sniffed and cleared her throat and said that she didn't care about this fact at all. (The sniff and clearing of throat here were felt to be expressions of the transference—an avoidance of feeling) (Fenichel).

(8) Patient sniffed and talked about a doctor's office in a Western city, very small and stuffy.

(9) Sniffed and said, 'I'd like a cigarette.'

(10) Association to a mental hospital window in a painting by a young friend of hers that was supposed to symbolize a desire for freedom—cough.

(11) Associations to a handsome man in another city—cough—who asked her for a date—cough—and took her to a graduation farewell dance—cough.

(12) Discussed a man she last saw a week before she left home; immediately following the word 'left' she sniffled and cleared her throat.

In this material we see frequent references to leavings and separations, one tangential reference to birth, and although there were references to enclosures, messy or stuffy rooms, there was no mention whatever of smell or of the actual menstruation during this hour. The frequent coughing and sniffing seemed related to unconscious fantasies around respiratory incorporation.

A related clinical note: A psychotic male with excessive narcissistic preoccupations stated that he had never in his life had a cold but had always found some of his deepest satisfactions from the smelling of his own and others' flatus. Just prior to his psychotic breakdown he had noticed that he had almost ecstatic states smelling his own flatus, and this was followed by bizarre fantasies of snakes crawling in and out of his nose. It seems here as if there had been no somatic barrier or ego defence against his atavistic impulses.

Analysis of a Woman Patient

In an extensively analysed case it was found that the fantasies around intercourse, impregnation, pregnancy, and birth were filled with particularly terrifying ideas. Castration and death were equated, and an attempt to ward off the recognition of death as an absolute, by obsessive spiritual speculation, including extensive philosophical fantasies involving eternity and infinity which in themselves later became charged with dread fantasies of punishment and retribution in hell.

The patient, a woman, aged 29, with severe agoraphobia of some five years' duration, claustrophobia, depressions, and nausea, had been in treatment with a psychiatrist for the preceding four years. She had had modified insulin therapy, adrenal desensitization, sodium amytal interviews, nitrous oxide treatment, and psychotherapeutic interviews. She had been hospitalized for a considerable

period during her treatment. The reason she had left the psychiatrist was that he had stated that there was no solution for her problem except a divorce. For the four years previously she had been unable to visit a theatre or to go out of her house unaccompanied by her husband. She also had found it absolutely impossible to be left alone at home without him, and these symptoms completely curtailed business trips which he would otherwise find necessary, as well as curtailing his natural gregariousness.

She had been a rather obedient child, not much trouble at home, compared with an older impulsive, misbehaving sister. The mother, a detached bright woman, spent little time in affectionate care of the children, but from an early age encouraged and sometimes forced an independent spirit on them. The father, a withdrawn, suspicious man, had lost all his money during the Depression. His attitude towards women was that they were promiscuous and smelly. The patient did not recall an affectionate relationship with the father, but felt that at any sign of sickness in her he withdrew. When she was in her late teens he suggested that her nose was a social drawback and insisted on surgery, which was done.

She went to college at 18, and although she developed a series of colds, had no other overt symptoms. Her heterosexual relationships were limited and when actual intercourse threatened she would fight the man off or flee in terror. At the time of her marriage she was a virgin.

The analysis started off with attempts on the patient's part to avoid any positive transference involvement. She was brilliantly and consistently negative, hostile, and critical, although certain positive aspects of the transference must have kept her in treatment. During the first year she became aware of her sadistic behaviour directed towards her husband, and of certain strong oral biting tendencies. These became clearly related to her fear of being in the street. She also realized that her claustrophobia and fear of being left alone were related to masturbation temptation. With the uncovering of strongly promiscuous wishes, she attempted to give up the clinging sadistic relationship to her husband. She herself left the house with more ease, and received a car which she could drive almost freely about the city traffic. When the patient

became aware of her prohibited promiscuous tendencies, the claustrum lost its defensive function and the street its threatening one. The husband began to take out of town business trips. The patient stated: 'Last year I never had any colds. I only had those symptoms. This year I don't have the symptoms but I have never had so many colds in my life.' (Each of these colds was related to the separation from her husband.) Gradually the analysis became more and more focused in the analytical situation. The patient, for a considerable time, attempted to ward off unconscious sexual wishes directed towards the analyst. She continuously and consistently denied quite obvious feelings of dependence. The patient recalled mother, grandmother, and servants attempting to force food on her and threatening that if she did not eat properly she would be sent out back with the garbage.

Her symptoms only gave way when the deeper oral levels were interpreted. She became aware of the fact that impregnation, conception, and childbirth fantasies were filled with terror. She had developed an elaborate fantasy of being born way out in space, but the loneliness and isolation plus cold frightened her. Whenever she assumed a feminine role during intercourse she would be seized with a severe panic and a wave of nausea. She attempted to overcome this by fantasizing that her husband was a faceless stranger. Her masturbatory fantasies were centred around voyeuristic and exhibitionistic tendencies.

The assumption of the role of wife and mother precluded any sexual gratification, and the patient came to recognize this as an attempt to live out the defensive fantasy: 'I cannot enjoy any of the pleasures which I considered were criminal and dirty in my mother.' Her restrictions on herself were a magical attempt to punish the incorporated mother. Whenever there was a threatening loss of the good mother figure (solicitous husband), she unconsciously attempted to regain the lost object by incorporation; she would eat chocolate and attempt to incorporate her husband by binding him to her with threats of hysterical disintegration. Understanding these oral mechanisms and working them through did not alter the anxieties until we began to analyse certain aspects of her colds. Beginning with the fact that whenever a cold occurred

she experienced loss of taste and smell, the defensive aspects of this 'anaesthesia' were emphasized. She began to experience certain threatening fantasies associated with respiratory incorporation. In the transference she re-experienced alarming fears of being gassed and poisoned and of being buried alive, suffocated. A psychiatrist previously treating her had attempted to overcome this by forcing her to take gas. She had felt that he could release this mysterious, odourless gas from a hidden place and she started to shake. When asked why *he* was immune from this gas she, surprised, realized that it had something to do with being a man, impregnable.

In addition, phenomena resembling osmic hallucinations (usually regarded as seriously pathognomonic) heralded the uncovering of memories of 'forgotten' objects, people important to her in early childhood.

Needless to say that with the appearance of these symptoms the analyst was considerably dismayed but, since retreat was impossible, the analysis was continued and led to the resolution of some of her problems. Certain of the olfactory symptoms were related to inter-uterine and pregnancy fantasies and had been augmented by the gassing and cremation of relatives and compatriots by the Nazis. Her attitudes to breathing were associated with deep reality distortions. She had unconsciously felt that a little death occurred at the mid-point of a sneeze when one was powerless to inspire.

She resisted many interpretations because of the unconscious fear of incorporating the analyst's dangerous breath. During one analytic hour the patient was talking about smells and recalled, as a child, that her mother had a distinctive smell, but that men smelt differently. The patient recalled that she believed smell was associated with sex—suddenly she developed a headache with pain in her nose and could not breathe. It was pointed out that associated with smell was the same fear of suffocation related to claustrophobia. At this point the patient said she could not hear my words. When it was pointed out to her that words had two qualities—sound and breath—the patient became extremely anxious and said she could not hear me—this was pointed out as a defence against incorporating my breath. This she understood. She said each word seemed to have a solidity—'That's why sometimes I can't talk

—each word I say fills the air and frightens me. I want to say a short sentence so that I won't have air too filled up with my solid words. It makes me feel claustrophobic with no room to breathe. I feel that this is all very crazy.'

It should be pointed out that the analyst was making cigars and his office did have quite an odour. In one hour the patient showed how she had split her attitude towards flatus. For a while she talked about her fear of gas and asphyxiation and of smells. Then she discussed her love of music. She associated sound with misty liquids, something orgasmic. She felt, listening to Schubert, as if it were gooey, kind of feminine—wallowing but nice and not repulsive. Here was an instance of the splitting up of the two aspects of flatus; sound, unlike smell, was highly pleasurable, almost orgasmic, and not something extremely dangerous to incorporate. At one time she could not sleep without listening to music.

Whenever a loss threatened, she attempted to regain the lost object by respiratory incorporation as well as by oral incorporation. The respiratory incorporation was related to the ghost or soul of the object, i.e. gas or flatus. Her fears were that the ambivalently loved object, unconsciously destroyed by her, would return to kill her, retaliating orally by poisoning and respiratorily by gassing her.

The fear of ghosts and the devil had been elaborated in her by an identification with a completely suppressed mother figure, a maid of another religion, who took her to church as a very young child and threatened her with eternal damnation and punishment in hell with fire and brimstone.

Whenever her husband left her, attempts to regain the lost penis = breast would centre round fantasies of being a prostitute, or orgiast who incorporated many penises in sexual promiscuity. Whenever she felt hostile to her husband prior to his leaving, she could indulge in such fantasies, but when she felt loving and tender towards him, as she did on occasion, these promiscuous tendencies were suppressed and she developed a cold.

One interesting association to her fears of being in the street was related to separation from home. As a little girl she recalled leaving the warm house when she should not have done so and running out into the street to play. When she tried to come back home, a strong

wintry wind blew into her face and against her. She prayed God to let her get back into the house, which she would never leave again, and had fears of being picked up by the wind and being blown away. During this hour her legs began to cramp and she recalled the feeling as a child of weakness and fatigue in her legs in attempting to fight the threatening wind.

She admitted to a longing to become a Catholic and submit passively to God, but this entailed giving up bodily desires and becoming strictly spiritual. Here we are reminded of Phyllis Greenacre's discussion in a paper 'Respiratory Introjection' about spiritualization as a defence against powerful masturbatory conflicts.

In the analysis it was quite common to see the patient blow her nose as a defence against her wishes to incorporate parts of the analyst. This act had many meanings. It resembled the conch shell or bull-roarer, and was an attempt to ward off ideas, thoughts, etc. (ghosts); it was a denial of castration—'I too can ejaculate'; the catarrhal discharge was a displacement of vaginal discharge or lubrication. The patient felt that the vagina was the same as the anus—a dirty, smelly cavity, and that sexual excitement led to secretion of a disgusting liquid which, however, was attractive to males. She covered herself with perfumes and completely suppressed her own sense of smell. Accompanying this was a reversal of roles in which she was the active impregnator. She wondered aloud how I could stand her smell without vomiting. When the interpretation was given that this reversal was a defence against her own passive receptive wishes, the patient suddenly became very warm from the waist up and cold from the waist down, and when these defences were interpreted, she said, 'I feel now as if I had a body, although my legs are numb and cold, I can feel my sexual organs. They are there and I can breathe again. I feel my thighs warming. I feel as if someone had awakened my body and a dark cloud had passed away. My nose, I can feel it falling apart as if someone had broken up icebergs and they are floating away. The cold is solid like a chunk of ice, not warm and misty like orgasm. The cold is like a dead body in my nose.' However, with this anxiety, the patient's attempt to deny transference took another form: 'But you have changed, you are different, like a ghost; I don't know whether friendly or threatening.'

The next hour the patient reported that the previous night her cold was intensely bad and she had attempted intercourse with her husband. 'As soon as my sexual feelings were aroused towards him my nose cleared up and I could breathe,' but the moment she came to the analysis her nose was all clogged up again. This defence was interpreted and the patient suddenly said she felt hot all over, perspiring, varying between shivers and a tremendous heat. She recalled a dream from the previous night. 'I was talking to my daughter and she said, "I told the doctor I had dreams about having babies and I feel much better now." I felt envy at her getting it off her chest.' The cold she then understood from the dream to be a defence against impregnation fantasies. The patient suddenly felt grateful and very warm towards the analyst, but then became stuffed up and could not talk. She expressed a wish that I fix her nose. Her nostrils became solid and tied up. 'If I could leave sex out of it, I could express my feelings about you. But my nose is so stuffed up I want you to put a warm needle into it to break it up. It would be a marvellous needle relief. A needle with something in it—liquid pouring out—is heavenly—like having an orgasm. Between the waist and the knees I am numb. My nose is all stuffed up, but I feel as if my genitals were anaesthetized. It would be like taking off all my clothes.' At this point the patient had extreme pain in her legs and felt she was getting a creeping paralysis.

The fear of impregnation was related to actual assaults on her body as a child. There had been forced feedings by her mother, grandmother, and nursemaids, to which she had reacted with a stubborn refusal to eat or with nausea. Later, when constipated, she had been given enemas, and the sensation had aroused considerable anxiety of swelling and then explosively bursting. This was unconsciously equated with pregnancy and birth. As a young child she had developed Vincent's angina and a mouthwash had been forcibly used on her. As she herself said, she felt that a cold was somehow a pregnancy allergy. The onset of her illness was strikingly related to the mobilization of these fears. She had become pregnant and seemed to be quite happy when suddenly she began staining and was put to bed. She stayed in bed the remaining eight months of the pregnancy, not really understanding what was happening or what

might threaten her, but feeling helpless and overwhelmed. This only strengthened her feelings that pregnancy was dangerous and threatened her life.

The patient realized that when she was angry and hostile towards her husband, she could have promiscuous fantasies. When she felt warm and loving towards him to any extent, she developed a cold on separation. The various components of the cold were related to the following feelings:

(1) An association with tears bound up with love, sadness and feelings of longing.

(2) Promiscuity and vaginal arousal were suppressed and displaced to the nose.

(3) Masturbatory impulses were suppressed and returned in a feeling of itchiness around the eyes.

(4) As a defence against seducing men she felt that she was dirty and men could not be attracted to her (actually the patient was quite attractive).

(5) Feelings of choking and coughing were related to a displaced oedipal struggle. The husband left her sometimes to visit his mother and the patient felt inferior and unloved and had actual fantasies of choking her mother-in-law.

(6) The perfume was a denial of her feminine castrated feelings, her menses; perfume was equated with penis.

(7) With the loss of the loved object, all incorporative fantasies, both oral and respiratory, were warded off by her nausea, loss of appetite, cold and loss of sense of smell.

Later during the analysis completely forgotten figures from her childhood reappeared. For example, following the feeling that my office smelled strongly of garlic, she suddenly recalled previously unmentioned paternal grandparents who had been subject to much devaluation (anti-semitism by the other side of the family) with whom it was dangerous to identify as they were related to the Jews so cruelly murdered in Hitler Germany (gassed).

In this case, at least, we came to understand the cold symptoms were related to fantasies of incorporation mobilized by the loss of an object. Why these fantasies were so dreaded became clearer when we understood her terrifying fears of pregnancy which were masochistically elaborated during her forced feedings and frequent enemata. In her attempt to shift her identifications, she had longed to become a Roman Catholic, submit to God and

deny her body, but this too led to conflict because of her fear of purgatory, hell, and eternal damnation. She could neither identify with the Jews, because they were gassed and killed, nor with the Catholics, because they became condemned to hell as were the Protestants. God himself was rather a terrifying figure in her early childhood, a great wind that could pick you up and hurl you off into space; so the need to cling to mother and home was reinforced by the fear of the outside world, of space (a fall from a swing at the age of 4, for which she blamed her mother, and an exciting game of being thrown in the air by her father, were additional factors reinforcing this anxiety).

In this case the fantasies around respiration had been charged with oral and anal libido; one resistance to accepting interpretations was based on a fear of incorporation of the analyst's breath; fears of being gassed were related to fantasies around gaseous fertilization; the colds she referred to as a 'pregnancy allergy'; in attempts to avoid severe sado-masochistic fantasies about birth and the birth processes, she had elaborate ideas around the Immaculate Conception, God, infinity, and eternity.

Each of her colds during a considerable period of analysis occurred with the husband's absence and was an overdetermined defence against wishes to regain the lost penis = breast by both oral and respiratory incorporation.

Discussion

The colds observed during treatment were divided into two general categories: those of a presumably contagious nature where more than one member of the family or group (dormitory, office, etc.) were affected; and those where the contagious aspects were not obvious, though not by any means excluded. Of this second group, a certain proportion were observed to be closely associated to losses and separations and even to mourning reactions. An infectious agent was never excluded in any of the cases, and epidemiological studies are certainly indicated.

One extensively analysed female case initially presented agoraphobic symptoms associated to separations and losses. These symptoms changed to severe colds under similar circumstances, and later on in the analysis to depression and mourning. In other female cases, although the defence mechanisms and the conflict situations

differed, the colds showed a relationship to separations and losses. In the male cases, evidence suggested that the colds were related to conflicts over feminine identification, complicated by the arousal of passive oral wishes. There were, to be sure, a number of colds where the conflict was not so visible and the symptom was never understood. A complicating factor was that the analyst's interest in colds seemed to stimulate an increase in the number of colds observed and reported by the patients, but this did not vitiate the objectivity of the observations recorded before the interest became so overt and since the interest has abated somewhat.

In the colds there was not merely a simple defence such as Holmes, Wolf *et al.*, formulated in their idea of a 'shutting out' mechanism. The cases could not be clearly called psychosomatic as at times they resembled hysterical conversion symptoms (Menninger) and at times depressive equivalents. They were never clearly psychosomatic, hysterical, or depressive, although at times it was quite clear that they occurred *instead* of these syndromes.

One of the most striking aspects was the frequency with which the patients referred to themselves as dirty, and the preoccupation with the sense of smell. The disgust was associated with the sputum, which was dealt with in a completely ambivalent way. At times it was swallowed and regarded as a good incorporation (see Saul). Sometimes it was projected or ejected as disagreeable, even dangerous, and although this suggested an anal derivation, it could as easily be related to an oral prototype, namely vomiting and regurgitation.

In one patient, during depressive episodes, there was a feeling that the mouth was foetid and dirty, and that the breath stank, and the patient in her isolation would frequently comfort herself by smelling her own breath. This recalls the observation that certain animals in captivity reincorporate their own faeces or sometimes, when sick, their own vomitus. There is also the common habit in young children of picking their noses and eating the crusts. Most significant is Spitz's observation that infants, deprived of maternal care, may attempt to regain the lost object by reincorporating their own faeces. In the above clinical material, mention has been made of the attempt to regain the lost object by respiratory incorporation, and the preoccupation with smells which had an anal connotation but, as Fenichel pointed out, did not fall in the sphere of anality, since the object may have anal

qualities, but the organ involved was not the anus but the nose.

Differentiation must be made between the two functions of respiration—breathing and smelling. Conflicts around breathing expressed themselves in the fear of suffocation, i.e. deprivation of air (certainly the first introject and the object of the most extensive anxieties). Air itself was not experienced as an object except in anxiety and fear of suffocation, but the sensory appreciations of breezes, steams, smells and smoke, were elaborated in a multitude of ways as restitutions, regressions, rituals (see anthropological data above) dealing with the central anxieties around life and death, and in philosophical attempts to understand the human soul. It is noteworthy that in Fenichel's *Psychoanalytic Theory of the Neuroses* there is only one reference to the 'soul', and that in Fenichel's own paper, 'On Respiratory Introjection'.

In the colds, although congestion made nose breathing difficult, mouth breathing was automatic, and anxiety over air hunger was not outstanding. The suppression of smell, and often of taste, was common. Smoking (a respiratory incorporation) was often markedly diminished, and with the amelioration of symptoms, increased again.

In some of the women patients there was an increased use of perfume during menses, consciously an attempt to cover a smell exaggeratedly associated with menses, but unconsciously serving as a restitution of the lost penis, i.e. the perfume itself penetrating the smeller.

Although all the clinical examples mentioned above were related to separations and losses, we can state that in these conflict situations the symptoms were predominantly in the oral and respiratory spheres. There were oscillations between incorporation and ejection, i.e. swallowing and spitting, sniffing and blowing the nose,

and even nausea or increased eating of sweets. Blowing the nose was observed frequently as an attempt to reject unwelcome ideas.

The close relationship of the oral (taste) and respiratory (smell) spheres is obvious, and may eventually help us to understand where to place the cold in the hierarchy of conflict, symptom, and defence.

Summary

The use of the word cold for a common catarrh led to examination of the words used in other Indo-European languages, which were found to be frequently associated with the terms for death, birth, pregnancy, and sexual arousal. In some clinical observations the cold was found to be related to losses or separations. Anthropological data showed the use of noises and stinks to ward off the return of ghosts following death, as well as defences against respiratory incorporation. Air was believed to carry ghosts and also the principle of life, and around this fantasy theories of conception, life and death had been elaborated. Following this lead, the respiratory and olfactory functions were examined.

Medically, the epidemiology of colds, although related to viruses, has not been specifically understood in the various syndromes classified under the term 'common cold'. Cold weather and other stresses may bring on colds. Nasal catarrh was discussed as a somatic response to stress, a shutting-out mechanism.

Clinically it was observed that colds and associated symptoms following loss or separation could be conceived as conflicts around oral and respiratory incorporation. In analysis it was shown that underlying certain colds were depressive symptoms, a withdrawal of object libido, and conflicts over unconscious attempts to regain the lost object through oral and respiratory incorporations.

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SYMPOSIUM ON 'REINTERPRETATIONS OF THE SCHREBER CASE: FREUD'S THEORY OF PARANOIA'

I. Introduction¹

By

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Half a century has elapsed since the death of Schreber and the publication of Freud's (1911) paper on his case. Now, with the benefit of fifty years of progress in psychiatry, psycho-analysis, and psychology, we turn to a re-examination of the case.

To provide sufficient background for the Symposium papers, an introduction to the Symposium and an account of Schreber's delusional system are presented.

Schreber has been referred to as psychiatry's most famous and frequently cited patient. He wrote *Memoirs of My Nervous Illness* in the years 1900-1902 and published it in 1903. Macalpine and Hunter, who translated the *Memoirs* from the original German manuscript, see it as the best text on psychiatry written for psychiatrists by a patient. In 1910 the *Memoirs* came to Freud's attention, and in 1911 he published his celebrated paper 'Psycho-Analytic Notes on an Autobiographical Account of a Case of Paranoia (Dementia Paranoides)'—an analysis based only on the actual text of the *Memoirs* and one additional fact, the patient's age at the onset of his illness. Freud specifically stated that he formulated his theory of paranoia before he became acquainted with the *Memoirs*, so that his analysis of the case was used as an affirmation, rather than as the source, of his theory. Freud wrote: 'It remains for the future to decide whether there is more delusion in my theory than I should like to admit, or whether there is more truth in Schreber's delusion than other people are as yet prepared to believe' (1911, p. 79).

Daniel Paul Schreber, born at Leipzig in 1842, was the middle child in a distinguished family. He had three sisters and one brother, his senior

by three years. His father was an eminent physician, for a time lecturer in medicine at the University of Leipzig, author of many medical books, the authority on child-rearing in the Germany of that day, leader of the German physical culture movement, and head of an institute of orthopaedics. In German-speaking countries allotment gardens are called Schrebergärten in his honour.

At the age of 36, Schreber married a woman fifteen years his junior. During the engagement period he suffered from a non-psychotic hypochondriasis. The marriage was childless; his diabetic wife had six full-term stillbirths.

Schreber was a distinguished jurist, and held several judicial posts. He ran for a seat in the Reichstag at the age of 42, at which time he developed his first severe mental illness, a psychotic attack of eight months' duration, with severe hypochondriacal symptoms and weakness in speech and locomotion. He was treated at the Leipzig Psychiatric Clinic by the famous neuro-anatomist Dr Paul Emil Flechsig. In 1893, aged 51, Schreber was appointed Senatspräsident of the Supreme Court of Saxony; seven weeks later he suffered his second mental illness. From 1893 to the end of 1902 he was confined first at the Leipzig Asylum, then at Lindenhof, and finally at Sonnenstein Asylum. During his confinement in the years 1896 to 1899 he wrote notes on scraps of paper and in notebooks; these were used in writing his *Memoirs*; in the last two years of confinement he took legal action leading to his discharge in 1902. His original purpose in writing the *Memoirs* was to acquaint his wife with his personal experiences and religious ideas to enable her to understand him and to adjust on his release to his persisting

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oddities of behaviour. It occurred to him later that a wide circle of readers might be interested in his unique insights into supernatural matters. In 1903 the Schrebers took a foster daughter, about 13 years of age, into their house (Baumeyer, 1956). After his mother's death, and immediately following his wife's sudden stroke in November 1907, he became severely psychotic, was admitted to an asylum, and died there in 1911.

A handicap faced by Freud and all who try to use the *Memoirs* to analyse the case is the deletion of all but two paragraphs of the key third chapter as unfit for publication. It is in this chapter that Schreber discusses the other members of his family and their relationship to the presumed soul-murder. Thanks to Baumeyer (1956) and Niederland (1951, 1959a, b, 1960) we are better off than was Freud in regard to knowledge of the family, since they unearthed much material about it.

The *Memoirs*, as interpreted by Freud, have been widely quoted but unfortunately are rarely read, so that according to Macalpine and Hunter a myth has developed around the legendary name Schreber. Only since 1955 have the *Memoirs* been available in English. The *Memoirs* are about 200 pages long; in addition there are postscripts, an essay on the justifiable conditions for commitment of the insane, and addenda consisting of five legal documents concerning Schreber's contesting of his tutelage—papers of import for medico-legal proceedings.

Schreber's second psychotic illness began with hypochondriasis, and assumed a violent course for two years, requiring him to be placed in a padded cell and at times forcibly fed. He manifested mutism, stupor, impulsiveness, attempted suicide, massive hallucination, delusions of persecution by Flechsig and God and of miracles performed upon his body, delusions about his surroundings, unbearable insomnia, compulsive acting and speaking, obsessive thinking, and transvestism. Macalpine and Hunter (1955) on checking lists of symptoms of psychopathology in an authoritative text of psychiatry found nearly all of them present in Schreber. Schreber emerged from his acute hallucinatory state with a paranoid delusional system that he was gradually becoming unmanned, perhaps asymptotically over time, so that 'by divine fertilization offspring will issue from my lap' (p. 214). On discharge the system persisted, and so did his transvestism and compulsive bellowing.

Freud (1911) interpreted this case and paranoia in general as the result of a homosexual fixation and failure of repression of homosexuality. The core of the conflict is the homosexual wishful fantasy of loving a man. The wish erupts owing to failure of repression and is projected on to the person loved in a form that denies 'I love him'—in Schreber's case—'He hates me'. Schreber's homosexual wish was first activated towards Flechsig, his psychiatrist, who became his persecutor, and was later transferred to God. Flechsig is, according to Freud (1911), a representation of Schreber's older brother and God of his father. The father complex is the key to Schreber's delusional system.

Macalpine and Hunter contend that Freud selected from the vast array of Schreber's symptoms only those elements dealing with persecution or lending weight to an etiological formulation based on unconscious homosexuality. They believe that doubt and uncertainty in sex identification and not passive homosexual wishes towards members of the same sex are the crucial factors in paranoia. It is this provocative contention and the fact that Freud analysed the case long before he wrote his *The Ego and the Id* (1923) that make it inviting to re-examine the Schreber case.

The Delusional System of Schreber as Described in His Memoirs

Just prior to his illness Schreber had the thought in a hypnopompic state that it must be rather pleasant to be a woman succumbing to intercourse (Macalpine and Hunter, 1955). The delusion of his gradual transformation into a woman was the major theme of his system, at first directed towards making him the object of sexual abuse and later towards redeeming mankind.

According to Schreber's delusional religious system, which might be called a 'neuronal or neurological theodicy', God is composed of nerves, the human soul is contained in nerves, and the soul-nerves return to God on the death of the body after a period of purification or testing. God rarely makes contact with living persons, and then only with gifted individuals to give them insight into the Beyond. God is subject to the Order of the World, the lawful relations between God and the living, which does not ordinarily permit Him to interfere directly in the lives of men except for the performance of miracles. God rarely dares to contact human

beings because human nerves in an excited state attract God so strongly that He is held fast to them. God extracts from corpses soul-nerves and raises them to a state of blessedness in the forecourts of heaven, the anterior realm of God, where they enjoy bliss—uninterrupted feelings of voluptuousness, continual enjoyment, and contemplation of God. God dwelt above the forecourts in the posterior realm. God was divided into a lower God, Ahriman, and a higher God, Ormuzd. God and the heavenly bodies, especially the sun, are intimately related, and are perhaps one and the same.

An act contrary to the Order of the World, soul-murder, caused a crisis in heaven and imperilled Schreber. Flechsig was accused of being the culprit, and at times even Schreber. A significant juxtaposition of sentences occurs in the *Memoirs* relevant to this point (Macalpine and Hunter, 1955, p. 68)—significant for the thesis of homosexual etiology. Schreber states that on the night decisive for his mental collapse, he had perhaps half a dozen pollutions. In the next two sentences he states that from that time on Flechsig kept up nerve-contact with him, and he suspected Flechsig of secret designs against him. He believed that something might have happened several generations back between the Schreber and Flechsig families amounting to soul-murder. A Flechsig, temporary recipient of God's rays, refused to return the rays, and conspired with the anterior realm of God to deny offspring to the Schrebers or to deny them entrance into professions involving close contact with God, such as nerve-specialist. Soul-murder is performed by a culprit to take over another person's soul to prolong his own life or to appropriate his mental powers for himself. Flechsig attempted soul-murder on Schreber; only on writing the *Memoirs* did Schreber first realize that God was the original instigator. The conspirators contacted Schreber with rays of God which became trapped in his body owing to his nervousness. A suspension of states of blessedness for all the deceased and a struggle in which God tried to extract His rays from Schreber's body ensued.

Methods employed to remove God's rays from Schreber's body were: unmanning him so that he could be used as a female harlot, killing him, and destroying his reason. The programme of unmanning boomeranged, since the female

nerves of voluptuousness put into him attracted God's rays even more strongly.

The Order of the World demanded the unmanning of beings who were in permanent contact with God's rays. In cases of world catastrophe with one male survivor, unmanning was necessary to enable the survivor to propagate the race. Until propagation was fully established, the earth was populated by 'fleeting-improvised men' or souls transitorily put into human shape by miracle. Flechsig abused this system by unmanning Schreber for harlotry and inveigling God into the conspiracy. Schreber was destined to win the contest, since the Order of the World favoured him. A policy of vacillation followed, in which attempts to cure and annihilate him alternated. Schreber suffered from a plurality of heads or several individuals occupying one skull. Departed souls were attracted to his head and dissolved there. Prior to vanishing they became 'little men', a few millimetres tall. Schreber was tortured by head-compressing machines, chest-compressing miracles, and removal of internal organs. Attacks on his reason included 'stopping him from thinking', writing down all his thoughts so as to exhaust his mind of ideas, compelling him to think incessantly, forcing him to complete unfinished sentences such as 'Why not', 'I shall' (Macalpine and Hunter, p. 172), and demonstrating his stupidity by his failure to defaecate when it was necessary.

Schreber began to improve after the destruction of most of the unpurified souls, conspirators against him. He accepted unmanning because he believed that there were no other persons alive owing to world destruction and hence it was the only method of renewing mankind. It became a duty for Schreber to cultivate voluptuousness in order to prevent God from withdrawing from him. He believed that his beliefs would revolutionize mankind's religion. He raised the interesting question (p. 213) '... what is to become of God... should I die?' His reply was perhaps a return to the normal Order of the World and a resumption of states of blessedness of which he would be among the first recipients. About himself, the patient said (p. 214): 'Whatever people think of my "delusions", they will sooner or later have to acknowledge that they are not dealing with a lunatic in the ordinary sense.'

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II. Observations on Paranoia and their Relationship to the Schreber Case¹

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This paper includes a brief review and evaluation of the major criticisms of the traditional theory of paranoia, followed by some general observations on paranoia regarding such issues as the role of hostility, the essential nature of a delusion, the megalomaniac aspects implicit in all delusions, and rationalization as a defence. An attempt will be made to relate these observations, where pertinent, to the Schreber psychopathology.

Although Freud's (1911) interpretation of the Schreber autobiography has frequently been subject to attack and criticism, a survey of the vast literature accumulated on the Schreber case can only impress one with the wisdom and insight revealed by Freud in his original formulation. No alternative explanation or theory of paranoia has been proposed which has merited comparable consideration, respect, and acceptance.

Major criticism of the traditional theory of paranoia elucidated by Freud has been centred around the invariability of the role of unconscious homosexuality in the dynamics of the disorder, in terms of varying ways by which the proposition 'I (a man) love him' presumably becomes transformed into a paranoid delusion. The striking contrast between Freud's formulation and the then current literature (e.g. Friedman, 1908; Gerlich, 1908), however, would lead to the conclusion that Freud's primary contribution was perhaps not his elucidation of a relationship between homosexuality and paranoia, but rather was his demonstration of a way of thinking (the psychodynamic approach). Through application of the defence mechanism of *projection*, the psychopathology of paranoia was made meaningful in the context of motivational dynamics and understandable in the light of life's experience, in a way not previously accomplished.

The theory that paranoid delusions are always a defence against homosexuality has been

challenged by evidence of two general types. First, many cases of paranoid symptomatology do not appear to reflect any homosexual problem. In one of the earlier reports challenging the Freudian theory, for example, Klein and Horwitz (1949) reviewed the case records of eighty patients selected from a group previously diagnosed as of paranoid state or schizophrenia, paranoid type. Only one-fifth of the group gave any expression of references assumed by the authors to have homosexual implications.

Further evidence in apparent opposition to the Freudian theory stems from case reports which demonstrate a co-existence of paranoid delusions and overt homosexuality, sometimes in patients who accept their homosexuality without apparent conflict (Bollmeier, 1938; Carr, 1958; Hastings 1941; Schmideberg, 1931).

Although seemingly contradicting the Freudian theory, such evidence is not so convincing as at first appears. The finding that case histories do not invariably reveal evidence of unconscious homosexuality is not conclusive evidence that homosexuality can be ruled out. For example, in a study of diverse overt psychopathology in identical twins, in which one twin was heterosexual and the other overtly homosexual, psychological tests revealed strikingly similar dynamics in both twins. Nevertheless, crucial factors related to the heterosexual twin's object choice did not become apparent until after 200 hours of free association interview (Carr *et al.*, 1960; Rainer *et al.*, 1960). Furthermore, the determination of the presence of homosexual dynamics is obviously an inferential process in which the levels of inference may vary significantly among observers, e.g. Knight (1940) v. Klein and Horwitz (1949).

Although the presence of both overt homosexuality and paranoia in the same patient would also seemingly challenge the adequacy of the Freudian theory, no contradiction exists when the basic distinction between conscious homo-

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sexuality and latent or unconscious homosexuality is kept in mind. Glick (1959) in a recent publication pertaining to homosexual panic, elaborates this distinction as follows: '... we must realize that manifest (conscious) and latent (unconscious) homosexuality are not one and the same thing; that they exist, speaking metaphorically and topographically, in different "areas" of the psychical system; that they pursue independent courses (the contents of the unconscious may always be considered to be unavailable to the ego and conscious mentation except through interpretation, and sometimes never available to consciousness under any circumstances), and that in a sense "never the twain shall meet".'

This distinction seems equally relevant for paranoia, where close inspection invariably reveals that the homosexual impulses being denied or reacted against are of quite a different kind from those which may reach overt expression. For example, although a patient may engage in fairly conventional homosexual practices, he may have to resort to psychotic defences against more unconscious and totally unacceptable sadistic and incorporative impulses.

These prefatory remarks related to evidence sometimes assumed to disprove the Freudian theory are not made to imply any sacrosanctity about it. They would suggest, however, that even the most debatable aspect of this contribution cannot be readily discounted in the absence of a more satisfactory alternative theory. As a theory, Freud's formulation has stood up remarkably well, serving to organize, predict, and give meaning to behaviour and facts not immediately apparent. For example, while Macalpine and Hunter insist that Freud's conclusion regarding homosexuality and castration threat in Schreber's dynamics was based on distortion and misinterpretation of 'procreation fantasies', other evidence attests to its predictive value. Macalpine and Hunter (1955, p. 24) write as follows: 'Freud's homosexual bias had led him to interpretation of castration anxieties in Schreber's illness, based more on theoretical preconceptions than on actual material. Indeed he appears to have misunderstood some of Schreber's fundamental delusions, such as being "unmanned"'. This was a fantasy of being transformed gradually over "decades if not

centuries" into a reproductive woman, carrying neither a castration threat nor passive homosexual wishes.'

The recently presented hospital records (Baumeyer, 1956) of Schreber's behaviour in the County Asylum at Sonnenstein (1894-1902), however, now reveal through an independent source that in that phase of his illness, Schreber appeared to have rather explicit castration and passive homosexual fears.³ While the etiological or dynamic relationships of such impulses to paranoia may yet be considered debatable (e.g. Ovesey, 1955; Salzman, 1960), the Macalpine and Hunter formulation is no less 'theoretical' nor any more 'factual' than the Freudian hypothesis.

In responding to some of the issues raised by the chairman's proposed outline for this symposium, I would like to consider modifications necessary in any reinterpretation of Schreber's memoirs in the light of developments in ego psychology since 1911. I would presume that there would be general agreement that the role of hostility would necessarily be given greater emphasis. In *Civilization and its Discontents*, Freud (1930) questioned how he could originally have 'overlooked the ubiquity of non-erotic aggressivity and destructiveness and ... failed to give it its due place in our interpretation of life.' He had dealt specifically with this factor in homosexuality in his paper, 'Some Neurotic Mechanisms in Jealousy, Paranoia and Homosexuality' (1922), in which he viewed ambivalence as a defence against homosexuality. In *The Ego and the Id* (1923) he again spoke of feelings of rivalry and aggressive drives as sources of the homosexuality against which paranoia was the defence.

Others have since given a more central position to the factor of hostility than was implicit in Freud's statements. Spring (1939) has viewed world destruction fantasies as a displacement of murder wishes from individuals to the whole world, a defence which is successful because one cannot do actual harm to the world. In offering an explanation of why overt homosexuality is fought with such intensity by the paranoid, Knight (1940) interprets the homosexual love as denying 'a terrific, repressed, anal-sadistic hate. The frantic need to deny this love in every way possible is due not to fear of

³ E.g. 'he imagined ... his penis had been twisted off by an instrument which he called a "nerve probe"; he maintained that he was a woman; but he also declared that he had to put up a strong resistance against the homosexual love of certain persons.'

In connexion with Schreber's castration fears, Dr. Niederland has recently called my attention to his newly uncovered data which indicate that castration was a procedure actually used in Flechsig's clinic for certain mental conditions. It is not unlikely that Schreber knew this.

social disapproval of homosexuality as such, but to intense anxiety for the safety of both subject and object because of the destructive, anal-sadistic wishes which accompany the attempt to love. . . . Gill (1947) in an unpublished manuscript on paranoid delusions has proposed that homosexuality and paranoia are both defences against hostility, so that homosexuality is not invariably present because it is only one possible defence against the major force, hostility. Jones (1931), Nunberg (1938), and White (1961) have also dealt explicitly with the factor of hostility in paranoid dynamics.

It would appear that the precipitating events in Schreber's illness must be viewed as events logically serving to instigate feelings of hostility, as well as homosexuality. That both kinds of impulses were fused in Schreber's delusion regarding Flechsig is not surprising in view of Mrs Schreber's 'worship' of the man whose picture, we are told, was kept on her desk for many years following Schreber's first attack of hypochondriasis. Mrs Schreber's act of 'gratitude' towards Flechsig would have offered constant reinforcement for Schreber's low self-esteem, facilitating the development of feelings of jealousy, competition, and rage. In this regard it is perhaps relevant to note that a major regression in Schreber's second illness apparently occurred during his wife's 'holiday' and that his final hospitalization in 1907 followed immediately upon his wife's stroke.

In spite of what would now represent rather common agreement on the 'ubiquity of non-erotic aggressivity and destructiveness', however, it would seem that the existing inadequacies about all theories of paranoia continue to centre around difficulties in conceptualizing the factor of hostility. These difficulties are inherent in the formulation of the dynamics of disorders other than simply that of paranoia, and stem, partly at least, from the absence of a conceptualization of hostility from which appropriate techniques of measurement might be derived on purely theoretical grounds.

Relevant to this issue is a study being completed at the College of Physicians and Surgeons (Schoenberg and Carr, 1962) on a modified form of psychotherapy with neuro-dermatitis patients. As a part of a twelve-session course of treatment designed to encourage and reinforce expressions of hostility toward the contemporary life figures, neuro-dermatitis patients have been interviewed and given psychological tests prior to the beginning of treatment. Independent ratings

based on interview, test, and therapy data would leave no doubt as to the role of hostility, its control and expression, as being related to the exacerbation of the skin difficulties. In attempting to generalize the specific psychodynamics operative, however, particularly with the discrepancies arising from the use of tests of varying degrees of ambiguity and structure, the author has become most aware of the limitations of general descriptions of hostility, either in terms of the conscious-unconscious dichotomy or in terms of any implied quantification: more v. less. More specific delineation of the psychodynamic patterns of all the major psychopathological disorders will come only through a clarification of the varieties and diverse manifestations of hostility in terms of such distinctions as rage, competition, greed, destructiveness, resentment, jealousy, etc. When such delineation is achieved in terms of their origin, control, and self-perpetuating tendencies, the relationship between paranoia and depression will also undoubtedly be clarified.

I would like now to deal with some specific hypotheses which have been suggested through a review of a number of cases with paranoid symptomatology and to examine their relevance in relation to the Schreber data.

As one cuts through the variegated symptomatology—often rich in dramatic symbolic expressions which sometimes only lure and entice the investigator away from the basic issue—the immediately obvious and hence frequently overlooked phenomenon is related to the basic nature of a delusion, i.e. an unalterable conviction maintained about a disordered perception, which remains untouched and uncorrected by what is represented by others as reality and 'common sense'. In the words of the medical expert's report to the court on Schreber, 'the patient is filled with pathological ideas . . . not amenable to correction by objective evidence and judgment of circumstances as they really are' (Macalpine and Hunter, 1955).

A question arises as to what type of experience may be conducive to the development of a reaction which is exempt from the ordinary influences of the pressure of logic and external persuasion. I would suggest that related to the origin of this phenomenon may be a finding which I believe is frequently present in histories of paranoid patients, i.e. that in early development there has been the experience of having others deny the validity of a perception experienced by the patient to be real and true.

This denial frequently constitutes a hoax or deception maintained by the family, sometimes centring around the major issues of living—legitimacy *v.* illegitimacy, sanity *v.* insanity, law-abiding behaviour *v.* criminality. This denial may be integrated into a continuing disturbance in communication such as is subsumed under such concepts as the 'double-bind' (Bateson *et al.*, 1956) and 'pseudomutuality' (Wynne, 1958). In fact, to be viewed by outside observers it would generally have to continue to occur in the context of some ongoing communication. Nevertheless, the basic hypothesis suggested is derived more from the theoretical conceptions of Hartmann (1956) and Schachtel (1947), than from the empirical findings of Bateson (1956) or Wynne (1958). The pathogenic influences I attribute to the original perception and deception would stem from rather specific visual or auditory events, necessarily first experienced at a time when the patient's own perceptual organization could not permit absolute certainty of interpretation, at a time before the child had learned, in Hartmann's terms, 'to anticipate the interaction of inner with outer reality' (1956). I would assume that only such temporally specific events could disorder the relationship between perceptual experience and the ordinary corrective influences in a way which then persisted throughout life.

We can only speculate on the kind of perception or deception which may have played such a role in Schreber's disorder. Some clue as to the presence of an ongoing disturbance in communication, however, has been given by the important biographical data supplied by Niederland (1959, 1960). It now seems likely that one issue may have centred about the father's sanity. Niederland's suggestion that the case history reported by the senior Schreber (presumably of a chance acquaintance suffering from 'attacks of melancholia, morbid brooding, and tormenting criminal impulses') may have been autobiographical, is, I believe, quite plausible. In any event, a system of therapeutic gymnastics which permitted the father to express sadistic impulses to his son while verbalizing a quite different morality, presented the son with diverse implications which the memoirs give no evidence of ever having been successfully resolved.

⁴ For those impressed by coincidence of numbers, it should be noted that Schreber reported that six spontaneous nocturnal emissions were decisive for his mental collapse, and that the extracts from the University Clinic for Nervous Diseases at Leipzig (Baumeyer, 1956) contain the entry: '6 April . . . patient wants to be photo-

Another inference presenting itself in a study of case histories is related to the presence of megalomaniacal trends inherent in any delusional system. Although Macalpine and Hunter (1956) conclude that megalomania is by no means an invariable concomitant of delusions of persecution, case histories would appear to support the contention that implicit in all delusions is the assumption that the persecuted is a very important person to be the central figure in the drama arising from his own projections. As indicated by Schreber, ' . . . everything that happens is in reference to me.' Salzman (1960) has viewed such grandiosity as basic to the paranoid development which then arises secondarily as a reaction to the rebuff which the grandiosity elicits from the environment.

Speculating on the possible origins of the varying degrees of megalomania inherent in all delusions, a suggestion consistent with many case histories is that an event likely to elicit such trends perhaps is one which in some way has served to validate one's unconscious fantasies. No better basis exists for feelings of omnipotence or omniscience than to have unconscious wishes realized. Consciously to wish for something and have it actualized is within the realm of natural, everyday, if not sufficiently usual experience; for a deeply repressed impulse or fantasy to be actualized, however, is in a different order of events. Such an event can apparently serve as a concrete representation of the bearer's own omnipotence. The nature of the feelings which may be precipitated (whether primarily of the uncanny, of panic, or of mania) may be dependent on the relative levels of the wish-fear.

The Schreber case offers rich data for speculating on the hypothesis that some events may have served to validate Schreber's unconscious fantasies. The data recently reported by Macalpine and Hunter (1956) that Schreber's wife had six full-term stillbirths, for example, are sufficiently unusual to warrant consideration. The assumption of White (1961) regarding the relationship between the stillbirths and Schreber's soul murder delusions appears plausible. It would also appear that these stillbirths, in actualizing Schreber's destructive impulses, may also have fed into the megalomaniac aspects of his psychopathology.⁴

graphed 6 times.' I am not certain that such coincidences are relevant. The legerdemain by which Macalpine and Hunter find the figure '9' reoccurring in Schreber's illness, in support of the role of 'procreation fantasies', suggests they might be quick to indicate that 6 is really 9 upside down.

One further issue is related to the defences operating in paranoia: although projection has been perceived as the major defence, other defences contribute in varying degrees to the kaleidoscopic and frequently complicated symptomatology which is observed clinically. Waelder (1951) has stressed the prominence of denial (even to the displacement of projection) as a major defence in paranoia. Searles (1961) has recently stated the belief that introjection, 'while less easily detectable' (than projection) 'is hardly less important', explaining the threat experienced by the patient as stemming at least partially from introjection or from distorted representatives of people not truly incorporated into the ego. To my knowledge, however, the defence not heretofore sufficiently incriminated is that of rationalization. In the accounts of others who have had paranoid episodes, as well as of Schreber, the role of rationalization is impressive in the stages that pass from perception through to referentiality and illusion, then to delusion and hallucination, and finally to paranoia. The intensity of the need for justification through elaboration and expansion and the organization of an explanation and acceptable rationale often appears directly related to the ultimate prognosis of the delusion. The nature of these rationalizations will also determine the delusion's social acceptability, covering such possibilities for the bearer, it would seem, as incarceration or sainthood, and sometimes both.

The model for Schreber's utilization of rationalization may well have been his father. The extensive rationalizations utilized by father Schreber were incorporated into a system of therapeutic gymnastics which won for him an enviable fame and prestige. In his rationalizations his son played for even higher stakes, but lost. But at some other time, in some other place, he may have met a more benevolent fate.

One final word in relation to the role of paternal and maternal influences in the genesis of paranoid dynamics. The degree of pathogenic influence of either parent differs significantly from case to case in the variations which arise in those disorders which encompass problems around sexual identification. The results of the previously reported study on identical twins with diverse overt psychopathology (Rainer *et al.*, 1960) appear consistent with the recent statement of Cooley (1959) which places emphasis on the part of both parental figures in responding differentially to the child in terms of sexual identity. While the parent of the same sex is usually assumed to be the model for appropriate sexual identification, the role of the opposite-sex parent, as the model of what one's own sex is not, is sometimes as important. The cruel fate dealt Schreber included among other things, it would seem, models who confused rather than delineated aspects of their son's identity as a man, and ultimately as a human being.

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III. Further Data and Memorabilia Pertaining to the Schreber Case

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In this paper, which is a continuation and extension of previous studies on various aspects of Schreber's delusional system and its intricate relations to his father's life and work (Niederland, 1951, 1959a, b, 1960), I wish to offer further material and documentary evidence pertaining to the famous case. In doing so I am aware that the method of presenting and using findings collected from outside sources, and not from the patient himself, differs from the accepted analytic method of gaining access to such data which in analysis, of course, originate from one source alone, i.e. the adult patient. In applied analysis as well as in child analysis this is different; also during psychotic episodes in the treatment of adult patients the method of gaining access to important material may legitimately change. I therefore hold that the procedure I employed in my search for source material on Schreber—the systematic collection and analytic evaluation of authentic data derived from *all* available sources—is both permissible and useful, not merely because it corresponds to the approach chosen by more illustrious predecessors (Freud, Jones, Greenacre, Eissler, etc.) in their respective fields of applied psycho-analytic investigation, but also because it enables us to correlate in the present case certain pathogenic events in Schreber's early life with some of his bizarre delusional formations in adulthood and thus to demonstrate what Freud (1911, 1938) has called the 'historical truth' in a number of these heretofore unintelligible phenomena.

If, for instance, the analytic study of some of the patient's more conspicuous delusions reveals such an unmistakable relation to his father's child-rearing practices as is exemplified in my findings on the otherwise incomprehensible *Kopfzusammenschnürungswunder* and *Steisswunder* (the 'head-being-tied-together-miracle' and 'coccyx miracle'), I think that we are

justified in assuming that the origin of these Schreberian productions is to be found in the early traumatic father-son relationship. It is difficult to avoid the conclusion that these 'divine miracles' described in the *Denkwürdigkeiten* in considerable detail and without too much psychotic distortion are derived from, or at least modelled on, the father's medical-orthopaedic procedures as the precursors of the later delusions. One has, in fact, only to drop the word *wunder* in the first neologism, i.e. *Kopfzusammenschnürungs(wunder)*,² in order to arrive at the realistic core of its meaning in the patient's actual childhood experience, when the father as a physician and constructor of a formidable array of orthopaedic apparatus contrived and applied a helmet-like tying device called a *Kopfhalter* to the child's head. Or, to understand the origin and meaning of the 'coccyx miracle' one has but to compare the respective passages in the writings of Schreber *père* and *fils*. Here is the father's forceful description of how children have to sit (Niederland, 1960): '... one must see to it that children always sit straight and on both buttocks simultaneously ... neither first on the right nor on the left side. ... As soon as they begin to lean back [on the chair], it is time to have them change their sitting position to an absolutely still, supine one. ... It is important to train children of this age [from 2 to 7] to acquire absolutely straight posture ... they should be forced to hold themselves upright and erect. ... This can be achieved by insisting that as soon as a child behaves [sits] in a relaxed or lazy way, he is made to lie down, if only for a few moments. ...'

The delusional elaboration of this paternal coercion with respect to sitting and lying down can be found in Chapter XI of the *Denkwürdigkeiten* where the 'coccyx miracle' is explained in the following way: 'Its purpose

¹ Read at the 33rd Annual Meeting of the Eastern Psychological Association, Atlantic City, N.J., April 1962.

² Schreber also speaks of *Kopfzusammenschnürungsmaschine*, thus directly pointing to a mechanical head-tying apparatus which, according to him, was applied to his skull.

was to make sitting or even lying down impossible. I was not allowed to remain for long in one and the same position or at the same occupation; when I was walking, they attempted to make me lie down, only to chase me promptly from my reclining position when I was lying down. The rays [God, father] seemed to lack any understanding of the fact that a human being, since he really exists, *must be somewhere . . .* (italics in the original).

As I have noted elsewhere, such comparative observations can be helpful in clarifying various other obscure phenomena emerging during Schreber's illness. A case in point is his frequent reference to those mysterious 'little men' that have been the subject of much discussion in the literature (Freud, 1911; Katan, 1950; Macalpine and Hunter, 1955). I am greatly indebted to Dr Robert C. Bak who was the first to draw my attention to their connexion with the numerous drawings in the father's *Ärztliche Zimmergymnastik* and other books which, indeed, are filled with drawings and sketches of little human figures in a great variety of physical poses, gymnastic exercises, calisthenics, etc. That these figures represent in all likelihood the realistic precursors of the delusional 'little men' later on can also be seen from the specific wording which the patient uses whenever he refers to them and their puzzling appearance. He calls them *hingemachte kleine Männer*, that is, men made or drawn (in the sense of produced), thus employing terms which point to their anal-sadistic derivation in his own thinking as well as to their relation to the bewildering little men-figures in the father's literary productions.

Other delusional formations which Schreber reports, such as being at times without a stomach ('I existed frequently without a stomach', he writes in the *Memoirs*, Chap. XI), that his 'gullet and the intestines were torn and vanished', that his skull was sawn asunder and perforated, and the like, appear to be connected with certain anatomical illustrations in the father's medical books which, published or reprinted during the years following the patient's birth, the latter must have seen in manuscript or galley proof form in early childhood and must have been overawed by the sight of vivid illustrations of dissected bodies and body parts (see D. G. M. Schreber, 1859). Since the father's anatomical volumes and medical writings were abundantly and colourfully illustrated, they must have acquired for Schreber the meaning which picture-books and illustrated fairy tales generally

have in childhood, with the one difference perhaps that the very copiousness of the dissected body material over which the father as physician and orthopaedist presided, lent itself to become fused with the body-building and body-coercing paternal practices *in concreto*, as it were, adding to the ever present castration threat in the early Schreber home. This was located in a wing of an orthopaedic-surgical *Heilanstalt* for deformed patients (Niederland, 1959a, b), and this lent itself to the elaboration of florid castration and sado-masochistic fantasies in a setting of surgical—orthopaedic gymnastic practice.

The illustration (Fig. 1) from Dr Schreber's *Pangymnasticon* suggests the possible derivation of another 'miracle' in the *Memoirs*, Schreber's puzzling *Mehrköpfigkeit*. In Chapter VI the patient reports: '... there was a time when souls in nerve-contact with me talked of a *plurality of heads . . .* which they encountered in me and from which they shrank in alarm, crying "For heaven's sake—that is a *human being with several heads*." I am fully aware how fantastic all this must sound to other people; and I therefore do not go so far as to assert that all I have recounted was objective reality; *I only relate the impressions retained as recollections in my memory.*' (Italics added.)

This picture shows heads coming out of one body in the fashion indicated by the patient. His statement about 'impressions retained as recollections' also suggests a measure of subjective awareness as to the possible origin of his delusional fantasies. Be that as it may, the findings seem to demonstrate Schreber's early childhood experiences not only as the 'kernel of truth' of some of his later delusions, but also as the core of the psychotic material 'miracled up' by the patient during his illness, when in his restitution efforts he attempted with the help of such experiences to regain the lost objects and to re-establish his unresolved infantile ties with them. One of the main features of this attempt at restitution consists, as Freud has shown, in an effort to recapture the lost objects by reinforcing the cathexis of verbal and non-verbal representations standing for them. Hence the plethora of names and dates in Schreber's productions, especially the multitude and deification of the names representing the father; hence also the great number of 'divine miracle' formations, their frequent repetition, neologistic naming, and detailed description in a steady flow of verbal material and delusional imagery.

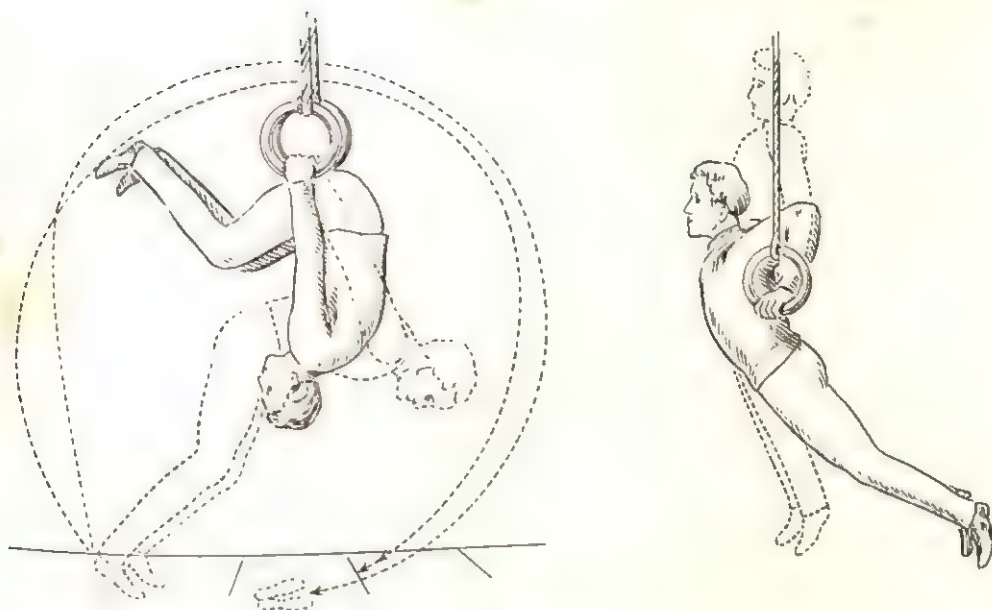


Fig. 1

It is well to remember that until a few years ago Schreber had been like a man without a childhood, a patient without a past. It is one of the ironies of analytic research that 'the most frequently quoted patient in psychiatry' (Macalpine and Hunter, 1955) has left virtually no data about his early life and that our inferences regarding his childhood and adolescence must be based on reconstructions. In this respect, of course, our patient is not unlike other psychotics who rarely, if ever, furnish sufficient evidence as to their developmental years and early family relations. Freud, to be sure, in analysing the *Denkwürdigkeiten*, soon discovered 'the shadowy sketch of infantile material' in them, as he put it, and left in his own words to us latter-day analysts the task of filling in the gaps and supplying additional data for a fuller understanding of the case history.

In pursuance of this task I wish to record some new, as yet fragmentary, but otherwise well-substantiated information which has come to light with respect to Schreber's mother, about whom nothing was known until very recently and who only now has become the subject of a valuable analytic study by White (1961). In the course of my search for authentic background material on the Schreber family I was fortunate enough to obtain a letter written by the patient's eldest sister, Anna, which dates back to 1909—two years before the death of the author of the *Denkwürdigkeiten*—and which contains the following remarks about her parents and their close relationship during her childhood: 'Father discussed with our mother everything and

anything; she took part in all his ideas, plans, and projects, she read the galley proofs of his writings with him, and was his faithful, close companion in everything.' Granting that a loyal daughter would tend to depict the parental relationship in such a harmonious fashion after the lapse of so many years (the father died in 1861, the mother in 1907), the apparently casual remark on her mother's working on the paternal manuscripts in personal collaboration with their author—that is, the very writings which are replete with the minute prescriptions, orthopaedic procedures and anatomical drawings later transmuted by the patient into the raw material for the 'divine miracles'—led me to reflect on the likelihood that the mother must have thus become, from the patient's point of view, the willing and active participant in the paternal practices, manipulations, and coercive procedures performed on the patient. It thus becomes likely, as has already been postulated by other authors, that the peculiar complexities of Schreber's God, the central figure of the *Denkwürdigkeiten*, with its division into anterior and posterior 'forecourts', upper and lower deities, and various other attributes, represent the condensed, archaically distorted fusion of both parental images in the son's delusional system. God, in this system, would then be the delusional composite of both father and mother, both projected and later regained as objects through the restitution attempts via the delusional fantasies about miracles and other 'divine' manoeuvres enacted on the patient's body. The fact that, according to the sister's

testimony, the mother helped and actively participated in those partly coercive, partly seductive procedures whose nature and significance I have discussed in my earlier papers, seems to lend support to this conclusion.

Further support along these lines comes from the discovery of new material regarding the patient's mother as well as from the *Denkwürdigkeiten* themselves. In the latter Schreber calls the sun and God in his angry outbursts a whore. With regard to the mother, whose name was *Pauline (née Haase)* I found that she was herself the third child of a prominent physician and professor of medicine in Leipzig, precisely as was her son *Paul*, our patient, who during his illness delusionally changed his sex to that of the mother and hallucinated about being 'Miss Schreber'. Other striking examples of Schreber's confusion regarding both his own sexual identity and the identity of paternal and maternal figures are contained in the following data obtained by me from the municipal archives in Leipzig: the maternal grandmother of the patient was *Juliana Emilia Haase*, wife of the physician and professor just mentioned. In the *Denkwürdigkeiten* the patient transforms his grandmother into a practising male physician named *Julius Emil Haase*. It may be said with certainty that, at least on the basis of my documentary material extending over more than a century of the Schreber genealogy, no male person of this name exists in his lineage, and that we are confronted here with a retroactive delusional change of sex by the patient, similar though in reverse to his own change of sex during the psychosis. He employs the same reversal, narcissistically elaborated, in the case of his paternal grandmother whose name was *Friederike née Grosse*; in a delusional footnote she becomes *Friedrich der Grosse*. This footnote can be found in Chapter II of the *Memoirs*, which deals with the delusionally exalted lineage of the Flehsig and Schreber families (the Schrebers had once had the title 'Margraves of Tuscany and Tasmania') and with an occurrence 'between perhaps earlier generations of the Schreber and Flehsig families which amounted to soul murder'. According to information I have recently received from the Stadtarchiv Leipzig the grandmother *Friederike geborene Grosse* died on 30 December, 1846, and it is likely that this was for our patient, then 4½ years of age, his first experience of the death of a close family member. The patient was born in 1842.

To return to the division of God into an

upper and lower one or into a superior and inferior deity, named by the patient Ormuzd and Ahriman respectively and spoken of by him as the 'hierarchy of God's realms', the role of the patient's elder (and only) brother in the structure of this delusional aggregate should be recalled. Freud already mentioned the probability that Schreber's peculiarly composed God in a sense had derived from paternal and fraternal roots contained in the delusional material. The new data confirm Freud's assumption. The brother, Daniel Gustav, who after the father's sudden death in 1861 became the head of the Schreber family, committed suicide in 1877 a few weeks after his promotion to become *Gerichtsrat* (judge) at a provincial Saxon Court in Bautzen. Since the otherwise reliable Baumeier (1956) suggests that the brother was a chemist and says nothing about the mode of suicide, I may be permitted to quote verbatim from the *Stadtarchiv-Bautzen* in Saxony which in its collection of municipal documents pertaining to the year 1877 has the following entry:

'Schreber, Daniel Gustav, Dr. Jur., Kgl. Gerichtsrat in Bautzen, laut Kirchenbuch St. Petri, Bautzen, gestorben 8. Mai früh, 38 Jahre, ledig. Selbstmord durch Erschiessen.' (Schreber, Daniel Gustav, Doctor of Law, Royal Judge in Bautzen, according to church register St Peter, Bautzen, died on 8 May, in the morning, 38 years old, unmarried. Suicide by gunshot.)

Several newspapers in Saxony carried under the date of 10 May, 1877 similar notices, some also mentioning that melancholia or depression must be regarded 'als die Ursache des traurigen Ereignisses' (*Chemnitzer Tageblatt*, 10 May, 1877, No. 111, p. 4). The newspaper further emphasizes that the suicide occurred only a short time after the brother's nomination. I consider this last point as well as the obituaries in the newspapers important, since Schreber delusionally indicates in the memoirs not only that he read his own death notice in the newspaper, but also that his 1893 breakdown occurred a short time after his promotion to become *Senatspräsident*. The identification aspects and their far-reaching effects in the Schreber case, with which I dealt previously, are particularly impressive here; various multiple cross-identifications are readily discernible in Schreber's pathology. In the *Memoirs* they are often expressed by the occurrence of certain names, dates, and more specifically by anniversary

reactions. All this can only be alluded to here, since their detailed consideration would require a separate study.

The sister's letter is of interest also with respect to some other aspects of Schreber's symptomatology. She describes in it in some detail how everything in the Schreber home was *gottwärts gerichtet* (oriented towards God), how God was present in their childhood world at all times, not merely in their daily prayers, but in all their feeling, thinking, and doings. She concludes the letter with the words: 'All this was finished with the sudden death of our beloved father . . . *unser Kinderparadies war zerstört*.' Here we may perhaps be permitted to view this statement as a non-delusional version of her brother's archaic 'end-of-the-world' fantasy and to contrast it with his delusional restitution attempt at a recapture of the lost childhood paradise through the reunion with God-father-mother-brother, i.e. through the formation of his particular God-aggregate of upper and lower parts, anterior and posterior courts, as the composite deified representation of the early objects.

In this respect certain features of Schreber's pathology, in particular the great number of the 'divine miracles' derived from or modelled on the early paternal-maternal manipulations, can also be understood as complex manifestations of a compelling, regressively reinstancualized need to recover or recreate at all costs the lost objects, something we are used to encounter in certain transference reactions of a stormy nature. These transference reactions, in relation to Schreber's physician, Dr Flechsig, his assistants and orderlies, are graphically described in the *Denkwürdigkeiten* and served Freud as valuable landmarks in his analysis of the case. The father of the patient was indeed an extraordinary man. Some of the passages about religion in the elder Schreber's books read as though written by one who, while not an ordained priest and not fond of dogma, had seen in a mystical way the true light of God. In studying his writings, I found that he was fond of lecturing and sermonizing to his children on the human body, the wonders of nature, and the relations of God to the universe, elaborating especially on the phenomena of magnetic attraction and repulsion in which he saw the expression of basic cosmic forces governing the universe. He built on these popularized pseudophilosophical system of his own, his *Weltanschauung*, writing and lecturing about it extensively. It is noteworthy that in the

son's delusional cosmology the paternal *Weltanschauung* reappears. Though distorted, condensed, and concretized, it emerges throughout the text of the *Memoirs* in a readily recognizable fashion as a conglomeration of philosophical, theological, and cosmological speculations in which divine rays, attraction to and repulsion by God, magic attributes of the deity, personal 'nerve contact' with the latter, and similar ideas predominate. The non-delusional raw material of most of this can be found in the father's medical and philosophical writings. To give only two examples here:

The father, in discussing the span of human life on earth, indicates two hundred years as the maximum age which human beings may attain in time to come. The son's delusional description of the end of the world contains this figure, two hundred years, as the approximate time limit set by him for the occurrence of the anticipated event. Again, one of the father's books has the sub-title *Der Wunderbau des menschlichen Organismus* (the miraculous structure of the human organism). The term *Wunder* appears in the *Denkwürdigkeiten* not only in constant connexion with God's miracles, that is, the father's 'miraculous medical' actions; it also is quoted directly by the son as *wundervoller Aufbau* and then explained by him in an almost insight-revealing footnote: 'Again an expression which I did not invent. . . . The term *wundervoller Aufbau* was suggested to me from outside.' From the sister's letter and other sources the origin of these notions becomes clear. The father, a passionate educator and eloquent talker, took his children on frequent strolls, citing to them the wonders of God, of the world, and of the body, with paternal pride and sermonizing insistence. During and after such lectures the children were questioned in minute detail as to their understanding of the cited wonders and the one who, like our ever obedient patient, knew the correct answers, received paternal praise.

Of interest is the onset of Schreber's first illness, about which little has been known until now. Freud, letting the patient speak for himself and strictly adhering to his self-imposed 'policy of restraint', only pointed to Schreber's passing remark about his candidature for the Reichstag in 1884. With respect to this candidature for election as a member of parliament, I wish to supply some of the following data. Schreber was then running for the Reichstag as the avowed candidate of the *Nationalliberale Partei* (National Liberal party) which was in opposition to

Bismarck's autocratic and reactionary régime in Germany. After a political campaign in which Schreber actively participated, the election took place on 28 October, 1884. Schreber was defeated, with an overwhelming majority voting against him (14,512 against 5,762), and a local newspaper in his election district—Chemnitz in Saxony—carried the somewhat scornful headline about his candidature: *Wer kennt schon den Dr. Schreber*—who after all knows Dr Schreber? A few weeks later he fell ill with his first sickness, in November 1884, which has been described as a hypochondriasis or a condition characterized chiefly by hypochondriacal complaints. The recently accumulated material indicates that Schreber, following his defeat, suffered from a severe depression, considered himself incurable, had difficulties in talking and walking and made two suicidal attempts. He was hospitalized for approximately six months (Baumeyer, 1956). He undoubtedly also had various hypochondriacal symptoms and, for instance, thought that he was going to die 'any moment'. On the basis of the old medical records discovered by Baumeyer (1956) it is clear that depressive and hypochondriacal manifestations were present during this first illness and that the depression was connected at least chronologically with Schreber's election defeat. Shortly after his unsuccessful campaign he developed a serious disorder which, among other symptoms, included speech disturbances and difficulties in walking, i.e. manifestations in all probability related to his active participation in the election campaign.

My data further suggest at least *one* reason for Schreber's disastrous political-personal situation (and his subsequent hospitalization) which resulted from his participation in the unsuccessful campaign. There is evidence that the Schreber family was in political difficulties with the governmental authorities in Saxony during the 1840s, especially during the revolutionary years 1847 and 1848, when the patient was 5 years of age or so. As I have explained elsewhere (Niederland, 1959b), the turbulent political

events in Germany during the 1880s seem to have revived in him memories and anxieties connected with his childhood experiences during the 1840s and to have contributed, in connexion with his political campaign of 1884, to a regressively intensified reliving of the castration fears of his oedipal years which had also been marked by political events and considerable uncertainties connected with fears of personal and political persecution.

Turning to the outbreak of Schreber's second and lasting illness in 1893, its chronological connexion with his promotion to *Senatspräsident* has been duly noted and has often been commented on in the literature. But here also a second, perhaps equally important, factor must now be added. Schreber's brother, *Daniel* Gustav, as we have seen, committed suicide a short time after his nomination as *Gerichtsrat*; the patient, *Daniel* Paul, tried to do the same a few weeks after his nomination to an even higher juridical position and, prevented from physical suicide, succumbed to lifelong mental illness. The father died in his early fifties in a Leipzig hospital on 10 or 11 November, 1861; thirty-two years later the patient had himself hospitalized, likewise in his early fifties, in a Leipzig hospital on 9 or 10 November, thinking himself dead and making several suicide attempts. The presence of strong intrafamily identifications is evident here (Niederland, 1959a).

In closing this brief presentation of supplementary material I wish to reiterate that I do not claim that the data so far accumulated throw light on the nature of Schreber's psychosis. Suffice it to say that some of them appear to be useful in our effort to unravel a few among the many obscure features in the clinical picture and to make hitherto incomprehensible aspects of Schreber's delusional system accessible to further investigation. It is well to bear in mind that *Denkwürdigkeiten*, this in Freud's view 'invaluable book', is no casual text of reminiscences. It contains not only the patient's mental productions, but also reveals on closer scrutiny the matrix from which they are formed.

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A Note on Dr Niederland's Paper

By

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In a personal communication to Dr Niederland I made an observation on a documentary finding reported in his paper, and he has suggested that I present it to this Symposium. He reported that Schreber's brother, Daniel Gustav, committed suicide by gunshot on 8 May, 1877.

In the *Memoirs* (Macalpine and Hunter, 1955, p. 91) the patient stated that round about Easter 1894 . . . I had visions according to which Professor Flechsig had shot himself either in Weissenburg in Alsace or in the police prison in Leipzig; I also saw—in a dream vision—his funeral procession moving from his house towards the Thonberg (that is to say not really in

the direction which one would expect according to the spatial relation between the University Nerve Clinic and St. John's Cemetery).—'I am, however, almost certain now that these visions did not conform to real happenings in the way I believed I had seen them.'

These passages suggest that the patient was actually recalling his brother's suicide and identifying Flechsig with his brother. This conclusion confirms Freud's thesis that Flechsig represented the patient's brother. Dr Niederland in a personal communication to me added that since Flechsig = Brother = Father = God, my observation supports Freud's main thesis on the Schreber case.

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IV. Schreber, Parricide, and Paranoid-Masochism¹

By

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In evaluating Schreber's *Memoirs* (Macalpine and Hunter, 1955), it must be borne in mind that they were written seven years after the onset of his major illness in 1893 from notes which were begun no earlier than 1896. When he began making notes he had already reconciled himself to his emasculation, and his severe psychotic phase was in a state of partial remission. The almost benign 'freedom from malice' and other unparanoid-like attitudes which characterize his memoirs are therefore more reflective of his condition when they were written than of the earlier condition which he describes. For example, in his 'Open Letter to Professor Flechsig' dated March 1903 he writes, '*I do not harbour any personal grievance against any person*' (Schreber's italics) (p. 33). Flechsig, who played such an important role in his early delusions of persecution, is referred to as one '*whose integrity and moral worth I have not the least right to doubt*' (Schreber's italics) (p. 34). It is, of course, well known that anyone suffering from paranoia has a whole arsenal of grievances at his disposal, and insists on his right to doubt the moral worth and integrity of anyone, including God himself; and Schreber does, in fact, recall having done so.

Even though his recollection of earlier experiences may be quite accurate, it is fair to assume that the selection of events recalled, as well as his attitude towards them, was dictated by the character and demands of his later adaptation. The deletion of Chapter 3 concerning his family notwithstanding, the importance of Schreber's mother has been for the most part overlooked. (Here it is pertinent to note that it was Dr Weber (p. 270), not Schreber, who recalled his bellowing: 'The sun is a whore.') Schreber's inevitable bias in favour of the more benign psychotic phase which obtained while he was writing his *Memoirs* makes the task of reconstructing his more openly violent paranoid period more difficult.

A number of writers call attention to Schreber's fear of failure after he was appointed *Senatspräsident*. But Schreber functioned well as long as he was wrestling with reality problems. It was only when he was successful in mastering his new position that his troubles began. 'I started to sleep badly', he writes (p. 64) 'at the very moment when I was able to feel that I had largely mastered the difficulties of settling down in my new office and in my new residence, etc.'

Schreber's appointment as *Senatspräsident* was a major *success*—a success which he unconsciously experienced as the acquisition of power great enough to challenge and overthrow God = Flechsig = Father. Schreber's unconscious wish to usurp God's place and power arouses God's retaliatory wrath (via projection) and Schreber, like the 'Prince of Hell' (p. 140), is subjected to dire punishment. While continuing to avow his adoration of God, he nevertheless reports '... the "Prince of Hell" appeared suddenly to have become a reality in my person. An enemy was therefore seen in me who had to be destroyed by all the might of divine power' (p. 140). He hears voices declaring, 'God's omnipotence has decided that the Prince of Hell is going to be burned alive', and other such denunciations (p. 140). With Schreber as with Satan in Milton's *Paradise Lost*:

'Him the Almighty Power
Hurled headlong flaming from the ethereal sky
With hideous ruin and combustion, down
To bottomless perdition, there to dwell
In adamant chains and penal fire,
Who durst defy the Omnipotent to arms.'

Only when as *Senatspräsident* Schreber placates God by yielding to his demand that Schreber undergo the deeply humiliating transformation into a woman, does he regain some measure of sanity and freedom from painful symptoms. He appears to renounce the para-

¹ Read at the 33rd Annual Meeting of the Eastern Psychological Association, Atlantic City, N.J., April 1962.

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noid struggle for power in favour of a more masochistic position. In Theodor Reik's (1941) formulation, he achieves 'victory through defeat'. By appearing to renounce power over God for the sake of God's love, he becomes God's most favoured woman. ('A very special palm of victory will eventually be mine: Mac-alpine and Hunter, p. 214). By wearing ribbons and cheap jewellery he pleases and impresses God by degrading himself. The relative safety of his masochistic position can be maintained and justified only by retaining his paranoid delusional system intact and distinct from the reality issues of his daily life.

Schreber's homosexuality, in this view as distinct from Freud's, does not represent so much the emergence of an infantile wish for libidinal gratification from his father, but is primarily defensive against the wish to kill and the dread of being killed by the father figure. He chooses to be castrated rather than annihilated. His sufferings then become a prior masochistic atonement which transforms the sin of sensual pleasure into a virtuous submission to God's will. Schreber boasted that he was a man of the highest morality especially in regard to matters of sex. For such a man a sense of profound degradation, at least at the outset, becomes the necessary condition for the enjoyment of voluptuousness. Freud's view that Schreber regressed to an earlier phase of psychosexual development provides only a partial explanation. Not only is Schreber's rage against his father overlooked, but the complexities involved in the phenomenon of regression itself are not fully acknowledged.

In 1911, when Freud wrote about the Schreber case, 'even crucial ego functions were conceived of in terms of instinctual drives'. It was not until 1937, as David Rapaport (1959) points out, that Freudian ego psychology entered its current phase and was developed mainly through the contributions of Erikson, Hartmann, Kris, and the vicissitudes of instinctual drives, and Schreber's regression, to be sure, did involve the emergence of an infantile homosexual phase. But Schreber's ego also regressed to a much more passive and dependent state. Schreber's regression was *in the service of his ego* (Kris, 1952) because it served to overcome his dread of destruction, and helped him to become more reality-oriented.

Moreover, Freud's view of homosexuality is much too restricted. His idea that the object of

the homosexual's choice must have genitals like his own may provide a foundation in childhood for identification with and emulation of the father figure, through which constructive process a heterosexual adjustment may eventually be achieved. But it ignores the psychodynamic ramifications underlying adult homosexual practice and fantasy. Fellatio, for example, is often a symbolic way of warding off punishment by placating the father figure; and is also accompanied by a hostile wish to drain off and incorporate his strength. Moreover, it is generally conceded, on the basis of current clinical knowledge, that the overt homosexual feels deeply alienated from his own sex and is deeply identified with his mother. Freud pays little attention to the role of the mother in the aetiology of homosexuality. At one point, however, in his paper (1911, p. 61) on Schreber he does observe, '... the infantile sexual theories which attribute the same kind of genitals to both sexes exert much influence.'

There are also indications that Schreber's transformation is accomplished not only by the replacement of nerves (through the agency of Flechsig, the nerve specialist, and a reliving of his childhood subjugation to his father's orthopaedic appliances) but also by the fantasy oral incorporation and anal retention of his mother. Schreber's unwillingness to eat meat during one period and his delusion that he was swallowing parts of his own body suggest conflicts about cannibalism. Could it be that when he finds himself replying to one of the voices that he cannot defecate because he is too stupid, he is already unconsciously one with mother? Since he could not effectively compete with father for mother's love, he regresses to the oral incorporation of mother and wins father's (God's) love. For Schreber the sun seems clearly a mother symbol. In this connexion I recall a paranoid patient who spoke of his ecstasy when he identified the setting sun as the red nipple on his mother's breast. Schreber's bellowing for hours on end, 'The sun is a whore', may well be his way of saying to God, the father, 'She is not worth fighting over'.

Freud's view that the paranoid elements should be clearly distinguished from the schizophrenic has considerable merit. Paranoid ideas and projections are usually ego-syntonic and are replete with self-righteous vindictiveness and obvious malice. Schreber's delusions and obscene vituperations are clearly ego-alien and completely contrary to the high principles of

what he regards as his usual character. Our chairman, Dr Kitay, using Baumeier as his source, has informed me that 'Schreber's sister, Klara Krause, remarked that Schreber had always been from quite a young age—hasty, restless, and nervous'. Schreber's self-characterization is in sharp contrast to his sister's view of him. He very consistently refers to himself as 'cool', 'sober', 'unemotional', 'efficient', etc. If he did not, in fact, manifest such character traits, such traits certainly did represent an ego-ideal with which he was striving to comply. Moreover, if the observations of his sister were completely true, it is difficult to imagine how he managed to achieve such outstanding success in his legal career. It is plausible to assume that the defence of cool intelligent efficiency was developed to cope with the trials of severe emotional instability—and that, in part, it served him well. But the very logic of such a defence demanded the repression of the powerful affects of rage and sensuality. Such affects when they breached his consciousness could not be integrated and overwhelmed his ego boundaries, first in the form of bodily symptoms and later in that of hallucinations and delusions. His schizophrenic symptoms are a function of inadequate ego-strength—of the incapacity of his ego to cope with the upsurge of powerful emotions at the pinnacle of his success. His paranoid-masochistic development, on the other hand, derives from the psychodynamics governing his repressed emotional life.

One may speculate, with the support of Dr Niederland's (1951, 1961) research, that Schreber's massive repression and its schizophrenic consequence had its roots in the bewilderment implicit in his peculiar childhood experience. His father, a distinguished physician, whose memory Schreber holds sacred, with the full cooperation of Schreber's mother ('the sun is God's instrument'), subjected his small son (was he 4 or 5 years old at the time?) to the constraint of appliances ('God knows nothing about the needs of living men') which caused him great pain. What seems most destructive to sanity is that such brutality was inflicted undoubtedly in the name of a most benevolent interest in the child's well-being (see the miracle of the creation of a false feeling, p. 130). Such an experience, we may assume, generated not only an intense but a deeply repressed rage—it

also promoted grandiose feelings. To be the centre of such concentrated, even if tormenting, attention, confers an extraordinary status on a child. In his final adaptation as a transvestite, its masochistic implications notwithstanding, Schreber's grandiosity continues to be proclaimed.

Paranoid-masochism

Schreber's *Memoirs* serve to support the thesis (Nydes 1963) that masochistic and paranoid psychodynamics are in polar relationship according to the formulation: the masochist appears to renounce 'power' for the sake of 'love'. The paranoid appears to renounce 'love' for the sake of 'power'.³

In such a formulation, the word love is not defined in an ideal sense, but is equated rather with interest, attention, sympathy, pity, concern, and endless variations and combinations of what are generally construed to be the rights of one who is dependent. It involves apparent submission to the love object. The word 'power', too, does not reflect constructive mastery or achievement so much as it implies, in this sense, power to enforce submission from others.

As the definitions of the words 'love' and 'power' imply, both orientations may be regarded as contrasting aspects of a struggle for 'power' with an omnipotent will. The masochist attempts to win love and, through suffering and submission, to force the 'omnipotent' person to serve him.

In the paranoid attitude, the need for love has become unconscious and would be despised as an expression of weakness. Both the paranoid and the masochistic character are driven by guilt. Both, in contrasting ways, employ judgement and punishment to defend against guilt. The biblical injunction, 'Judge not lest ye be judged' is revised by the masochist to: 'I judge myself lest you judge me'; and by the paranoid to: 'I will judge you lest you judge me'. While the masochistic character confesses and submits, the paranoid character accuses and imposes. Both dynamics frequently appear in combination.

While the limited conceptions of 'love' and 'power' outlined above are referred to quite frequently in the psycho-analytic literature on masochism, they have not been applied with equivalent pertinence to the psychodynamics of the paranoid character. One reason for this may

³ By referring to our talks together and to my lecture notes, Theodor Reik quotes and discusses this view in

his books, *Myth and Guilt* (1957, pp. 395–396), *Jewish Wit* (1962, pp. 226–228) and *The Need to be Loved* (1963).

be that the designation 'sado-masochistic character' has been used to identify psychic phenomena which in this view may more appropriately be termed paranoid-masochistic. Paranoid and sadistic features (Nunberg, 1955) are, to be sure, frequently intermingled and mutually reinforcing. But it may prove helpful to attempt some distinctions: sadistic hostility is primarily *reactive* against real injuries, both past and present. It involves identification with the aggressor, and is usually discharged against a less threatening object. (The captain slaps the lieutenant; the lieutenant slaps the private; the private slaps the peasant; and the peasant kicks the goat.) Paranoid hostility is primarily *defensive* against an assumed attack, involves self-righteous identification as the victim, and is discharged against the assumed aggressor. The assumed aggressor is almost invariably an authority figure against whom a repressed, guilt-laden fantasy transgression has been perpetrated.

Any attempt to interpret Schreber's *Memoirs* necessarily involves numerous assumptions and deductions. Mine are as follows:

(1) Schreber's rage against his father was deeply repressed largely because of his father's apparent benevolence and distinguished reputation. Repression was implemented by the attempt to cultivate a predominantly obsessional character structure based on efficiency and unemotional rationality.

(2) His rage against his father was intensified and compounded by both reactive and defensive features. It was reactive against his father's brutality which was probably inflicted during Schreber's oedipal period when he was about 4 or 5 years old. It was defensive against his guilt for wishing to destroy his father and usurp his father's place with mother.

(3) Schreber's unconscious rivalry with Dr Flechsig, whose picture Schreber's wife kept on her desk for years, repeated an infantile rivalry with his father.

(4) Schreber retained encapsulated an infantile image of his father as God. In order to

destroy him, Schreber himself had to become God.

(5) His appointment to the position of Senatspräsident stimulated his own feelings of infantile omnipotence. His reality success was pressed into service of his infantile needs—and a paranoid power struggle with God ensued. He appears to renounce his need for God's love and protection for the sake of power over God. In spite of his claims of moral superiority and invulnerability, Schreber never quite succeeds in killing God. Instead his own destruction seems imminent. But Schreber continues to fight. It is as if like Satan he would cry out:

'Then cursed be thy love, for love or hate
To me alike it deals eternal woe'.

But rather than be annihilated Schreber finally yields to the humiliating condition that God imposes in return for his love and protection. Schreber must be castrated. He must accept transformation into a woman. He appears to renounce power for the sake of love.

(6) Schreber improves only as he yields to a more masochistic position and is no longer in an open contest with God. In the end it is as if Satan, the paranoid, is transformed into Christ, the masochist. Schreber compares his own martyrdom to the crucifixion of Christ (Macalpine and Hunter, 1955, p. 214). But unlike Christ he now has the reward of sensual enjoyment. Instead of God's rival he becomes God's wife. Only as he maintains that delusion is he able to ward off God's wrath; and only in such security in pleasing God as a transvestite is Schreber able to regain some measure of sanity.

Schreber's *Memoirs* illustrate very clearly the contrasting reactions of the paranoid and the masochist to persecution and suffering. The paranoid justifies his aggression and continues to fight. The masochist submits and then claims the reward of being consoled and loved by his conqueror. Now God must use his omnipotent power on behalf of his victim, whose unconscious claim to omnipotence was, after all, only infantile.

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V. The Schreber Case Reconsidered in the Light of Psychosocial Concepts¹

By

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The purpose of this symposium is to reconsider the Schreber case in the light of the advances in psycho-analytic theory that have been made in the half-century since Freud's classical paper. Most notable among these advances have been the concepts of ego-psychology, particularly the concepts of Hartmann, Kris, Loewenstein, Erikson, and Rapaport. This growth in psycho-analytic ego-psychology has been succinctly summarized by Rapaport (1959), and the development of psycho-analytic theory generally was treated more extensively by him in 1960.

My reconsideration of the case will be made in terms of Erikson's concepts of psycho-social stages of personality development. Space does not allow an extensive effort to relate this view of the case to the other new concepts of ego-psychology or to the basic concepts of libido theory, particularly the concept of psycho-sexual stages of development; I reconsider the case, therefore, in terms of only one of the several sets of new concepts that have been placed at our disposal in recent years, and I largely omit consideration of libido theory. Let me emphasize a point that has not been sufficiently noted by many authors who have restudied the Schreber case, a point especially ignored by Macalpine and Hunter (1955); a study of any case from any one point of view, libido-concepts, ego-concepts, or psychosocial concepts, must be incomplete. Freud's (1911) formulations were made in terms of libido theory and of the Oedipus complex. These were the concepts, and the only ones, then available. They are obviously incomplete in the light of our present knowledge. But a study of the case from any one of our more modern points of view only would be equally incomplete.

Secondarily, I wish to underline Schreber's conflict with his mother, an important but rarely emphasized factor in his illness that is promi-

nently, although only symbolically, represented throughout the *Memoirs*. With the rare exception of such authors as Fairbairn (1956) and Searles (1961), Schreber's mother is either not mentioned at all in papers on the case, Freud's paper for instance, or she is mentioned only briefly as a shadowy counterplayer to the father in Schreber's oedipal struggle. Symbolic representation of conflict with a mother-figure, in my opinion, is one of the most prominent and consistent themes in the *Memoirs*, a view that I have elaborated upon elsewhere (1961) and that has been corroborated by Searles (1961).

Despite the clear symbolic references in the *Memoirs* to a mother-conflict, and despite considerable evidence in other data on the case that such mother-conflict was an important aspect of the case, the Schreber who is portrayed in most of the psychiatric literature seems to be motherless. The lack of interest in Schreber's relation to his mother is all the more striking in view of the emphasis in recent years on the importance of the earliest mother-child relation in the etiology of schizophrenia and homosexuality.

Erikson's theory of psychosocial development, an epigenetic theory, is especially noteworthy because it is the only systematic psycho-analytic conceptualization of the stages of development of personality beyond adolescence. Concepts of personality development that emphasize the importance of the events of adult years as well as those of childhood and adolescence are especially helpful in understanding the onset of Schreber's breakdowns, something otherwise difficult to explain, as Freud himself noted.

According to Erikson, the human develops at the embryological level according to a pre-determined ground plan during the pre-natal period, and his development continues in an

¹ Read at the 33rd Annual Meeting of the Eastern Psychological Association, Atlantic City, N.J., April 1962.

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equally orderly fashion at the social, interpersonal level from birth onward to senescence. He believes that the development of the child's personality 'obeys and on the whole can be trusted to obey inner laws of development, namely those laws which in the [the] pre-natal period had formed one organ after another and which [in the post-natal period] create a succession of potentialities for significant interaction with [others] around him' (Erikson, 1950, p. 63).

He proposes eight stages in the development of personality each of which arises in a pre-determined sequence and at a phase-specific point of the human life cycle. Here is a chart of the psycho-social stages of development in Schreber's life compiled from data now available from the work of Baumeyer (1956), Macalpine and Hunter (1955, 1956), Niederland (1951, 1959a-b, 1960), and myself.

As the foregoing shows, each psychosocial stage of development is designated by a pair of nouns of more or less opposite meanings—trust versus mistrust, autonomy versus shame and doubt, and so on. Each of these eight stages

culminates in a developmental crisis that results from a 'decisive encounter' (Erikson, 1959, p. 53) between the person and his environment. As new capacities and a new perspective on life evolve at each new stage the person must have yet another decisive encounter with his environment and its particular ideas of the values and behaviour that are desirable in a person of his age if he is to continue to develop into the kind of person the society needs. The outcome of this encounter determines the basic position the person will take somewhere between the polar extremes for that stage. For example, take the stage of trust versus mistrust. Each infant, after the fundamental experience of being cared for by the mother, prepares to leave this stage of maximum dependency. If the baby has found the mother to be trustworthy, a maternal attribute that depends not only on how much the mother feels she can trust herself but also on how much she feels she can trust her spouse, her family, and her immediate community, then the child acquires a basically trusting attitude towards himself, other

PSYCHOSOCIAL DEVELOPMENTAL STAGES IN SCHREBER'S LIFE

Age (years)	Psychosocial stage	Event's in Schreber's life
0-1	Trust v. Mistrust	Training in the 'art of renouncing'.
1-3	Autonomy v. Shame and Doubt	Crying, whimpering, and stubbornness treated ruthlessly so as to make parents 'master of the child forever'.
3-6	Initiative v. Guilt	Masturbation, 'that insidious plague of youth', stamped out by incessant vigilance of parents. Sadism avoided by banning of all pets because they might prompt children to acts of cruelty.
6-12	Industry v. Inferiority	Compulsively good manners and studiousness pounded into child.
12-20	Identity v. Identity Diffusion	Good posture enforced by various orthopaedic braces. Schreber age 17 (1859): Brother (Gustav, age 20) developed a 'progressive psychosis'. Father, age 51, received severe head injury and began to suffer from 'peculiar head complaints' that continued until his death three years later. Schreber age 20 (1862): Father died unexpectedly. Had suffered from an 'obsessional neurosis with homicidal impulses'.
20-35	Intimacy v. Isolation	Schreber age 35 (1877): Gustav (who never married) committed suicide at age of 38 years. Schreber engaged to be married. Schreber age 36 (1878): Married a diabetic, childish, 21-year-old woman. Schreber developed his first hypochondriacal symptoms.
35-50	Generativity v. Stagnation	Schreber age 42 (1884): First hospitalization for 'hypochondriasis' (actually was an overt psychosis). Two stillborn children prior to this.
50 +	Integrity v. Disgust and Despair	Schreber age 51 (1893): Became Supreme Court Judge in October 1893. Hospitalized, acutely psychotic, in November. Four more stillborn children prior to this. Wrote <i>Memoirs</i> during this hospitalization. Schreber age 60 (1902): Obtained his own release from hospital. Schreber age 65 (1907): Mother died, May 1907. Schreber's symptoms increased. Wife had stroke (14 November). Schreber became acutely psychotic. Hospitalized for third time (27 November). Schreber age 69 (1911): Died in State hospital. Freud wrote his study.

people, and later towards life and the hereafter. But no child finds it possible to trust completely. All his needs, some of which are innately insatiable, cannot be met. Every child, therefore, suffers some sense of disappointment, hurt, betrayal, and loss of the blissful unity he once had, or fantasied having, with the mother. From this inevitable trauma and from the host of others that might have been avoided if fate or parent had been kinder stems the reservoir of basic mistrust that is within all persons to varying degrees.

Erikson (1959, p. 61) warns of the danger of oversimplifying his schema: 'One of the chief misuses of the schema presented here is the connotation that the sense of trust (and all the other *positive* senses to be postulated) is an *achievement*, secured once and for all at a given stage. In fact, some writers are so intent on making an achievement scale out of these stages that they blithely omit all the *negative* senses (basic mistrust, etc.) which are and remain the dynamic counterpart of the positive senses throughout life. (See, for example, the 'maturation chart' distributed at the National Congress of Parents and Teachers at Omaha, Nebraska [1958], which omits any reference to crises, and otherwise 'adapts' the stages presented here.)

'What the child acquires at a given stage is a certain *ratio* between the positive and the negative which, if the balance is toward the positive, will help him to meet later crises with a better chance for unimpaired total development. The idea that at any stage a *goodness* is achieved which is impervious to new conflicts within and changes without is a projection on child development of that success ideology which so dangerously pervades our private and public daydreams and can make us inept in the face of a heightened struggle for a meaningful existence in our time.

'Only in the light of man's inner division and social antagonism is a belief in his essential resourcefulness and creativity justifiable and productive.'

But let us turn from psychosocial concepts to the events of Schreber's life. At the age of 36, shortly before his marriage, Schreber developed his first symptoms, hypochondriasis. These symptoms and his rather late marriage to an immature, 21-year-old woman of much lower social status than his own both suggest difficulty in resolving the crisis of intimacy versus isolation, a crisis which Erikson (1950) states must be adequately resolved if the person is to be able 'to face the fear of ego-loss in situations which call for self-abandon: in orgasms and

sexual unions, in close friendships and in physical combat, in experiences of inspiration by teachers and in intuition from the recesses of the self' (p. 229). Schreber's terrifying delusions clearly reflect conflict over intimacy; for example, his belief that either he would be destroyed by 'nerve contact', a delusional sexual intimacy with God, or that he would by such intimacy destroy all the rest of humanity and even God himself. In this regard Schreber states, 'When . . . there was reason to fear a dangerous increase of attraction [of Schreber's body] on God's nerves, then the destruction of the human race . . . could occur. . . .' (Macalpine and Hunter, 1955, p. 73); 'The power of attraction . . . harbours a kernel of danger for . . . God. . . .' (p. 59); God had to 'make all attempts to avoid the fate of having to perish in my body. . . .' (p. 150).

At the age of 42, after six years of marriage, two stillborn children, and a defeat in politics, Schreber developed his first overt illness, an illness that both he and Freud called hypochondriasis rather than a psychosis. Thanks to Baumeier (1956), we know that this bout of 'hypochondriasis' was an overt and severe psychosis for which Schreber was hospitalized for six months.

By being born full term but dead each of Schreber's children increasingly burdened its father's compulsive defence against his jealous, destructive impulses towards them, a matter of some importance, I believe, in causing both this first breakdown at the age of 42 and the second breakdown nine years and *four more* still births later. As I have tried to demonstrate elsewhere (1961), Schreber's very primitive, unresolved, voracious dependence on a mother-figure that was defended against by all-out identification with his compulsive father very likely made him especially ambivalent towards his own children. His inner primitive longing to be his mother's (wife's) only child became abundantly clear during his second and more severe psychosis when he developed the delusional belief that 'Since God entered into nerve-contact [a delusion of sexual contact] with me exclusively, I became in a way for God the only human being, . . . the human being around whom everything turns, to whom everything that happens must be related and who therefore, from his own point of view, must also relate all things to himself' (Macalpine and Hunter, 1955, p. 197).

Not only did each dead baby further burden Schreber's defences against his own destructive

jealousy towards it, each dead baby also withheld that enrichment of the ego which Erikson ascribes to a successful resolution of the generativity crisis, a crisis for which the decisive encounter for most people is parenthood (Erikson, 1961, p. 160). The developmental task of this stage ordinarily is that of 'establishing and guiding the next generation . . .'. Successful resolution of this crisis is possible only for the person who has developed some 'absorbing object of a parental kind of responsibility' (Erikson, 1950, p. 231) and an 'affiliation with others equally whole . . . and equally ready and able to share in the task of *caring* for offspring, products and ideas' (Erikson, 1961, p. 159). Both Schreber's immature wife and his stillborn children denied him such vitally needed assistance. Those who fail adequately to resolve this crisis 'suffer the mental deformation of self-absorption, in which he becomes his own infant and pet' (p. 160). Schreber does precisely this in his delusional idea that at times he was 'in sexual embrace with myself' (Macalpine and Hunter, p. 210) and that he was for God 'the only human being . . . around whom everything turns . . .' (*idem*, p. 197).

At the age of 51, nine years after his first breakdown, Schreber reached a new stage in life when he was appointed Chief Justice, the highest professional position, probably, that he could hope to attain. This appointment symbolized for him the beginning of the final chapter in his life. Four more stillborn children, a total of six (Macalpine and Hunter, 1956, p. 35), left him childless and the only surviving male member of his family; Schreber now confronted both the approaching end of his own life and that of his entire lineage. Thus he entered the life crisis which Erikson has designated as that of 'ego-integrity versus despair'. Within a few weeks he began a long struggle to resolve this final crisis by a psychotic regression to his first and never settled crisis with the mother—the crisis of trust versus mistrust.

A successful resolution of this final stage in the life cycle is possible, Erikson states, only for the person who 'in some way has taken care of things and people and has adapted himself to the triumphs and disappointments adherent to being, by necessity, the originator of others and generator of things and ideas—only he may [develop a true sense of integrity]. I know no better word for it than *integrity*. Lacking a clear definition, I shall point to a few attributes of this state of mind. It is the acceptance of

one's own and only life cycle and of the people who have become significant to it as something that had to be and that, by necessity, permitted of no substitutions. It thus means a new different love of one's parents, free of the wish that they should have been different, and an acceptance of the fact that one's life is one's own responsibility. It is a sense of comradeship with men and women of distant times and of different pursuits, who have created order and objects and sayings conveying human dignity and love' (Erikson, 1959, p. 98).

Elsewhere Erikson states, 'The lack or loss of this accrued ego integration is signified by fear of death: the one and only life's cycle is not accepted as the ultimate of life. Despair expresses the feeling that the time is short, too short for an attempt to start another life and to try out alternate roads to integrity. Disgust hides despair' (1950, p. 232). One could hardly ask for a better summation of the essential characteristics of Schreber's delusional fears and anxieties.

At the age of 51 Schreber faced the final developmental crisis of his life handicapped by a psychological deficit that had gradually accrued from the inadequate resolution of the crises of intimacy versus isolation and of generativity versus stagnation. Furthermore, we have good reason to assume that the two earliest and most basic stages of development, those of trust versus mistrust and of autonomy versus shame and doubt, had never been adequately settled, leaving Schreber in his adult years with an impaired capacity for trust and hope and a shaky sense of autonomy and will. Schreber's accumulated psychological debt became more than he could sustain as he struggled with the final crisis of his life. He collapsed and fell back to the first crisis, that of trust versus mistrust, a crisis that can be successfully resolved only if the person's first encounter with people is with 'trustworthy maternal persons who respond to his reach for *intake* and *contact* with appropriate provision, and prevent experiences of the kind which all too regularly bring too little too late' (Erikson, 1961, p. 153). By providing such care the mother becomes for the baby an 'inner certainty as well as an outer predictability' (Erikson, 1950, p. 219)—the basis for a sound sense of trust in the baby and a healthy sense of hope in the adult. Among the most prominent features of Schreber's second psychosis was his mistrust, hopelessness, and terror of being betrayed—as he puts it in his *Memoirs*, his

terror of being 'forsaken' by those on whom he was dependent.

The circumstances of the onset of this second psychosis clearly demonstrate the importance of conflict between Schreber and his mother, especially conflict over matters of trust and mistrust. When his symptoms became severe shortly after his appointment as Chief Justice, Schreber consulted Dr Flechsig who had treated him during his earlier bout of 'hypochondriasis' nine years previously. Concerning their first interview Schreber stated that Flechsig spoke of 'newly discovered sleeping drugs, etc., and gave me hope of delivering me of the whole illness through one prolific sleep, which was to start if possible at three o'clock in the afternoon and last to the following day'. Schreber and his wife obtained one of the newly discovered drugs that Flechsig prescribed, and they went to the house of Schreber's mother where the 'prolific sleep' was to be induced. It was there that his psychosis erupted when the narcosis was attempted. He states: 'Naturally I did not get to bed (in my mother's house) as early as 3 o'clock, but (possibly according to some secret instruction which my wife had received) it was delayed until the 9th hour. More serious symptoms developed again immediately before going to bed. Unfortunately the bed was cold because it had been aired too long, with the result that I was immediately seized by a severe rigor and was already in a state of great excitement when I took the sleeping drug' (Macalpine and Hunter, 1955, p. 65). Thereupon Schreber's psychosis erupted and he was hospitalized the next day.

Emphasizing the hopelessness and mistrust that overwhelmed him in the first days of his illness, Schreber describes how he was brutally thrown into a solitary cell where he was left to his fate, regarding himself as 'totally lost'. He states, 'I was completely ruled by the idea that there was nothing left . . . but to take [my] life' (*idem*, p. 66).

During the next several weeks in the hospital Schreber was tense, agitated, and unable to sleep. When his wife left his bedside for the first time after several weeks of nearly constant vigilance, Schreber immediately became worse and developed the delusion that she was dead. Shortly thereafter his delusions of 'nervel contact' and of being feminized began. He believed that he was becoming a woman and developing breasts because female nerves were pouring into his body from his dead wife and

from God. This influx of feminizing nerves was, as I have suggested in an earlier paper (1961), very likely a delusional symbolic oral incorporation of the lost wife-mother, a primitive, delusional effort to possess her by becoming her. According to Schreber's delusions, God's nerves poured into him at such a rate that the Deity was in danger of being destroyed by his own passionate longing to enter Schreber's body, a situation that endangered all humanity as well as God. The projected greedy, possessive, and destructive longings to be the sole possessor of the mother that are implicit in this set of delusional ideas have been considered at length in my previous paper. Here I can only note that his delusional belief that God longed to flow into Schreber's body is a projection of Schreber's primitive oral longing to possess and suck empty a mother-figure—a point of view that Searles has supported in 'Sexual Processes in Schizophrenia' (1961).

The father's medical writings on methods of childrearing give support to the assumption that Schreber's early childhood experiences quite likely created great difficulties for the resolution of his developmental crises of trust versus mistrust, autonomy versus shame and doubt, initiative versus guilt, and industry versus inferiority. We are indebted to Niederland (1951, 1959a-b, 1960) for much that we know of these publications of the father.

Schreber's father, the leading expert in all Germany on childrearing, stated that babies should learn the 'art of renouncing' (Niederland, 1959b, p. 387) within their first year of life. His directions to parents for teaching this were simple and direct. The child should be placed on the lap of his mother or nanny; she should then eat or drink whatever she wished. No matter how much the baby might beg or cry, he was to be fed nothing until his regular mealtime. He was then and there to learn the 'art of renouncing' while being held gently but firmly in his mother's lap. One lesson was not considered sufficient, and Dr Schreber urged frequent repetitions of these exercises in renunciation. It is hard to imagine a better way to foment paranoid rage and devastating mistrust in an infant. The return of Schreber's infantile struggle over these issues is documented on nearly every page of his *Memoirs*.

Another bit of advice on childrearing from the elder Schreber is highly relevant to his son's conflict over the crisis of autonomy versus shame and doubt. The father stated, 'crying and whimpering without reason express nothing

but a whim, a mood, and the first emergence of stubbornness; they must be dealt with . . . through serious words . . . , or if all this be to no avail, through . . . repeated, corporeal admonishments' (Niederland, 1959b, p. 387). The good Doctor adds, 'Such a procedure is necessary only once or, at most, twice—and then one is master of the child forever. From then on, one glance, one word, one single menacing gesture are sufficient to rule the child. . . .' There are few better ways to crush a child's autonomy or to instil stubborn defiance.

Concerning the stage of autonomy versus shame and doubt, Erikson (1959, p. 68) states that if parental control is too rigid or too early it will rob the child of his ability gradually to control his bowels, himself, and his relations with others. He may then regress to more primitive oral efforts to control by sucking his thumb and becoming demanding and whiny. He may become hostile and defiant, sometimes using his faeces or later dirty words as ammunition. Or, finally, he may develop a façade of control and orderliness—a pseudo-autonomy.

In childhood it seems that Schreber developed a veneer of pseudo-autonomy, going on to become a capable student and later a seemingly independent and successful jurist without ever having been truly autonomous as a child. In his psychotic regression, however, Schreber's unresolved autonomy struggle came back in full force. He complained that God cruelly and arbitrarily coerced, manipulated, and humiliated him—even to the point of interfering with his ability to defaecate when and where he wanted to. At such times God would taunt Schreber with the comment, 'Why do you then not sh...?', and then God would make him answer, 'Because I am somehow stupid' (Macalpine and Hunter, 1955, p. 178). In return, however, Schreber would defiantly hurl the filthiest invectives at God and would arrogantly insist that he was 'entitled to sh... on the entire world' (*idem*, p. 177). Thus, the ultimate in autonomy was mixed with the deepest shame and the most paralyzing loss of autonomy over bodily functions.

Of special relevance for Schreber's developmental stage of initiative versus guilt is his father's urgent plea for all parents to maintain an 'incessant vigilance' against that 'insidious plague of youth', masturbation, which, he

states, '. . . makes the unfortunate [youngster] stupid and dumb, fed up with life, overly disposed to sickness, vulnerable to countless diseases of the lower abdomen and to diseases of the nervous system, and very soon makes them impotent as well as sterile' (Niederland, 1959b, p. 390). He was equally fierce in his comments to parents about pets for children, warning that the sadistic side of the child's nature would surely be unduly stimulated by the temptation to commit acts of cruelty to the animals.³

We know, of course, from data unearthed by Baumeier that the elder Schreber himself suffered from an "obsessional neurosis with homicidal impulses" (1956, p. 62). We can reasonably assume that he also was in great conflict about his own impulses to masturbate—the fervour of his campaign to stamp out the practice betrays him badly.

The elder Schreber was apparently successful in his campaign to stamp out sensual and sadistic impulses in his son—at least for a time. Schreber states in his *Memoirs*, 'few people have been brought up according to such strict moral principles as I, and have throughout life practised such moderation especially in matters of sex . . .' (Macalpine and Hunter, 1955, p. 208). In his psychotic regression, however, all that had been so ruthlessly stamped out in Schreber by parental force in his childhood returned with added fury. The *Memoirs* are replete with references to every form of pregenital and genital sexual acts and to the most primitive sorts of murderous rage. As suggested in my former paper (1961, p. 67), the perpetrator of 'soul murder', a mystery of Schreber's delusional system that requires considerable detective work to unravel, is Schreber himself—not God, as Schreber protests.

Concerning the stage of initiative versus guilt Erikson states, 'It is at this stage of initiative that the great governor of initiative, namely, conscience, becomes firmly established. Only as a dependent does man develop conscience, that dependence on himself which makes him, in turn, dependable; and only when thoroughly dependable with regard to a number of fundamental values can he become independent . . .' (Erikson, 1959, p. 80). Erikson goes on to say, 'One of the deepest conflicts in life is the hate for a parent who served as a model and the executor of the conscience but who (in some form) was

³ For these data about the senior Schreber's views on pets I am indebted to my colleague, Hendrik Lindt, for his excellent translation of a section of Dr Schreber's

book, *Das Buch der Erziehung an Lieb und Seele* (1865). Dr Norman Reider kindly gave me access to this volume from his personal library.

found trying to "get away with" the very transgressions which the child can no longer tolerate in himself. These transgressions often are the natural outcome of the existing inequality between parent and child. Often, however, they represent a thoughtless exploitation of such inequalities; with the result that the child comes to feel that the whole matter is not one of universal goodness but of arbitrary power.' Such a sense of indignation and hatred against God is of course the hallmark of Schreber's attitude towards the Deity.

Concerning the development at this stage of pathological guilt, of which Schreber had much, Erikson states, 'The child now feels not only ashamed when found out but also afraid of being found out. He now hears, as it were, God's voice without seeing God. Moreover, he begins automatically to feel guilty even for mere thoughts and for deeds which nobody has watched. This is the cornerstone of morality in the individual sense. But from the point of view of mental health, we must point out that if this great achievement is overburdened by all too eager adults, it can be bad for the spirit and for morality itself. For the conscience of the child can be primitive, cruel, and uncompromising...' and lead to 'lasting resentment because the parents themselves do not seem to live up to the new conscience which they have fostered in the child' (Erikson, 1959, p. 80). Such a formulation seems precisely to fit Schreber's symptoms and the methods of childrearing inflicted upon him in his early years. It also helps to answer more fully the problem that Freud posed: 'No attempt at explaining Schreber's case will have any chance of being correct which does not take into account these peculiarities in his conception of God, this mixture of reverence and rebelliousness in his attitudes toward him' (Freud, 1911, p. 409).

In conclusion let me touch briefly on the developmental stages of industry versus inferiority and ego-identity versus identity diffusion. Having failed to resolve adequately the crisis of trust versus mistrust Schreber apparently solved the next developmental crisis by developing a pseudo-autonomy primarily by means of an intense identification with his compulsive father. Schreber's compulsive character structures were sturdy stuff. They allowed a resolution of the crisis of initiative versus guilt that appeared surprisingly adequate, at least outwardly. Later events in Schreber's psychosis show, however, how pathological, how primitively cruel and childishly corrupt

was the conscience that arose at that stage. But, nonetheless, Schreber coped surprisingly well with the tasks of the next developmental stage, that of industry versus inferiority. He developed a seemingly well ordered and well functioning ego-structure, and became a diligent and capable student.

Concerning the stage of industry versus inferiority, Erikson states that this is the 'time to go to school' (1959, p. 83). The child learns the pleasure of work completion through steady attention and persevering diligence. The critical conflicts of this period come more from outer hindrances than from instinctual drives. Erikson states, 'This stage differs from the others in that it does not consist of a swaying from a violent inner instinctual upheaval to a new mastery. The reason why Freud called it the latency stage is that violent drives are normally dormant at this time. But it is only a lull before the storm of puberty' (p. 88).

Schreber became a diligent and capable student, perhaps in good measure *because* of the help he received from the contraption that you see in Figure 2 showing a child hard at work at his studies and held in good posture by one of Dr Schreber's gadgets. I am being, of course, somewhat facetious—but only somewhat. It is quite possible that Dr Schreber's compulsive and suppressive methods of childrearing, methods that he practised as well as preached, were ego-supportive for his son, especially so at this stage of industry versus inferiority, a stage coinciding roughly with the latency period. At this time children welcome parental help in suppressing and repressing the instinctual storms of the oedipal phase.

In this regard both Loewald and Erikson have pointed up the supportive, noncastrating aspect of the relation of fathers to their children, an aspect of the relation of the child to his father that is often too little emphasized in analytic literature. Loewald (1951, p. 16) notes that the identification of a son with his father lends the boy 'powerful support against the danger of the womb', that little emphasized fear of the mother that stems from the child's primitive 'dread of the womb, dread of sinking back into the original unstructured state of identity with [the mother]...' Erikson (1958, p. 124) states: 'In anxiety and confusion, children often seem to take refuge from their fathers by turning back to their mothers. But this occurs only if the fathers are not there enough, or not there in the right way. For children become aware of the



FIG. 2. Taken from Niederland (1959a, p. 158) who quotes Dr Schreber as stating that this device was capable of 'preventing any attempt at improper sitting. . . . It comes in two forms, one recommended for private use [in the home] and one, in a more simplified form, for use in schools, particularly for the first two grades in elementary school' (1959a, p. 155).

attributes of maleness, and learn to love men's physical touch and guiding voice, at about the time when they have the first courage for an autonomous existence—autonomous from the maternal matrix in which they only *seem* to want to remain forever. Fathers, if they know how to hold and guide a child, function somewhat like guardians of the child's autonomous existence. Something passes from the man's bodily presence into the child's budding self—and I believe that the idea of *communion*, that is, of partaking of a man's body, would not be such a simple and reassuring matter for so many were it not for that early experience. He who never felt thus generated, "grown", as an individual by his father or fathers, always feels half annihilated, and may perhaps be forced to seek a father in the mother—a role for which the mother, if she assumes it, is blamed afterwards. For there is something which only a father can do, which is, I think, to balance the threatening and forbidding aspects of his appearance and impression with the guardianship of the guiding voice. Next to the recognition bestowed by the gracious face, the affirmation of the guiding voice is a prime element of man's sense of identity. Here the question is not so much whether in the judgement of others the father is a good model or a bad one, but whether or not he is tangible and affirmative. Intangibly good fathers are the worst'. Whatever else we might say of Dr Schreber, he was not intangible to his children.

Although the good Doctor's system of child-rearing seems exceedingly harsh to us, Erikson makes another point about such matters that is worth noting: '... a traditional system of child care can be said to be a factor making for trust, even where certain items of that tradition, taken singly, may seem irrational or unnecessarily cruel. Here much depends on whether such items are inflicted on the child by the parent in the firm traditional belief that this is the only way to do things or whether the parent misuses his administration of the baby and the child in order to work off anger, alleviate fear, or win an argument, with the child or with somebody else (mother-in-law, doctor, or priest)' (Erikson, 1959, p. 63).

Dr Schreber's methods may have helped both to resolve his son's oedipal conflict and to arm him for the onslaught of instinctual tensions of adolescence and the crisis of identity versus identity diffusion. Concerning this crisis of identity versus identity diffusion in Schreber's life, we have few data. I can only conjecture that he weathered the storms of puberty reasonably well because of his intense identification with his compulsive father. This identification probably helped considerably in the management of the instinctual conflicts of childhood and adolescence, but, as we noted earlier, it may well have made Schreber vulnerable to the adult problems of intimacy versus isolation. It was when he reached the crisis of intimacy versus isolation

that Schreber's severe difficulties became manifest. The hypochondriasis that occurred at the time of his engagement to be married warned of the approach of the paranoid and hypochon-

driacal psychotic symptoms that overwhelmed him during his generativity crisis six years later after a defeat in politics and the first two still-born children.

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VI. Summary¹

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In contrast with the six blind men of Hindustan grasping different parts of a living elephant and obstinately disagreeing about its configuration, we have on this panel four insightful men, three from New York and one from Texas, with individuality of apperceptive background and set, arriving at very similar conclusions upon examining the long-since departed Schreber. The conclusions arrived at were more frequently shared than unique. The panelists all cogently pursued psychodynamic and functionalist formulations, searching for greater specificity in the exposition of the origins and significance of symptoms. All expressed the Freudian 'Geist' in their dedication to psychodynamic explanations. If they found fault with Freud, it was mainly that Freud did not push his own principle of dynamic formulation far enough and broadly enough. But it has to be remembered that Freud himself, as Niederland repeatedly reminded us, spoke of his 'policy of restraint' in interpreting the Schreber case and accordingly refrained consciously from interpreting all its aspects.

The classical Freudian interpretation of paranoia and of the Schreber case was viewed as giving initially insufficient recognition to the importance of hostile destructive drives. Indeed, in later works Freud (1922, 1923) spoke of such hostile destructive elements, especially in the early sibling relation, as important components in paranoid or paranoiacally tinged formations. The panelists also acknowledged that Schreber's conflicts with his mother were very influential in the etiology of his illness. Particular stress was placed upon the factor of 'common front of the family against the patient', i.e. oppressive treatment from parents in agreement with one another involving hypocrisy and deceit which would lead to the development of mistrust and strong need to deny reality. Rivalry between Schreber and his father for his mother's affection, and probably also between Schreber and

his brother, consistent with Freud's later views on paranoia (1922, 1923), was seen as an important factor in the development of his illness.

Both Carr and Nydes considered the study of the interrelationships between hostility and homosexuality crucial for an understanding of paranoia. Carr took note of the hypothesis that the anal-sadistic component in homosexual love was the source of the threat to the paranoid patient, whereas Nydes postulated that homosexuality was defensive against both parricidal wishes and the danger of retaliatory destruction of the patient. The latter maintained that Schreber sought a masochistic surrender to God-father because of guilt over his fantasied unbridled, infantile, omnipotent, and overpowering rage against his father. White emphasized the importance of aggressive, voracious dependency needs, Schreber's wish to be the only and beloved infant of his mother-figures, and his consequent failure to cope with the developmental crisis of generativity versus stagnation or to develop a true sense of integrity.

It was held that megalomania was a reaction to the focusing of concentrated attention by sadistically oriented parents upon the patient during his developmental years. It was also maintained that it developed out of the experience of having unconscious wishes fulfilled by real events. Specific factors in the etiology and course of Schreber's illness emphasized by individual speakers included the following: failure to overcome fear of ego-loss entailed in intimacy (White), infantile omnipotence aroused by success in receiving appointment to the position of *Senatspräsident* (Nydes), surrender of power-seeking in order to obtain love (Nydes), and multiple cross-identification and confusions in identifications (Niederland). Macalpine and Hunter's thesis that archaic fantasies of ambisexuality and problems of creativity and immortality were central in the Schreber case and in paranoia in general was not found promising.

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from the standpoint of factual support or of heuristic value.

Niederland, continuing his documentation of the Schreber case, has demonstrated convincingly that there is much factual support for the Freudian interpretation of the case and much reality basis in the delusions of Schreber. He implies that the delusions of the paranoiac can be interpreted like the manifest content of dreams, and that there is a reminiscent recapitulation of childhood experiences in the delusional system of the paranoiac. He has presented newly obtained documentary support for the conclusion that Schreber perceived his mother as an ally of his father in the coercive child-rearing programme to which he was subjected and that he sought a regressive delusional reunion with the lost love objects of his childhood, namely God, father, mother, and brother. Niederland has submitted documentary evidence that Schreber in his delusional religious system was identifying with his father's cosmology.

That progress has taken place, since the 1911 formulations of Freud, can be seen in the more comprehensive, broader, and more specifically

delineated analysis of dynamics and object-relations introduced by the speakers; in the readiness to accept greater flexibility in theoretical formulations; in attention being given to the phenomenological world of the patient during his childhood; in consideration being given to the developmental factors determining weaknesses in reality-testing, autonomy, and trust; and in emphasis being given to defences other than denial and projection in the study of paranoia.

Many diverse and yet similar formulations have been presented to serve as a frame of reference for future analyses of paranoiac patients. The panelists have not written 'finis' to the case of Schreber. Rather, it is hoped that they have encouraged renewed interest in it by gaining the attention of an audience capable of testing empirically the formulations offered and of developing them further. It seems most suitable to conclude with the comment that much truth has been demonstrated in Freud's theory of paranoia and many kernels of historic truth found in the delusions of Schreber.

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SYNOPSIS OF AN OBJECT-RELATIONS THEORY OF THE PERSONALITY

By

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In response to many requests I have prepared the following brief synopsis of the theoretical views I have expounded over the last twenty years. (See bibliography.)

- (1) An ego is present from birth.
- (2) Libido is a function of the ego.
- (3) There is no death instinct; and aggression is a reaction to frustration or deprivation.
- (4) Since libido is a function of the ego and aggression is a reaction to frustration or deprivation, there is no such thing as an 'id'.
- (5) The ego, and therefore libido, is fundamentally object-seeking.
- (6) The earliest and original form of anxiety, as experienced by the child, is separation-anxiety.
- (7) Internalization of the object is a defensive measure originally adopted by the child to deal with his original object (the mother and her breast) in so far as it is unsatisfying.
- (8) Internalization of the object is not just a product of a phantasy of incorporating the object orally, but is a distinct psychological process.
- (9) Two aspects of the internalized object, viz. its exciting and its frustrating aspects, are split off from the main core of the object and repressed by the ego.
- (10) Thus there come to be constituted two repressed internal objects, viz. the exciting (or libidinal) object and the rejecting (or antilibidinal) object.
- (11) The main core of the internalized object, which is not repressed, is described as the ideal object or ego-ideal.
- (12) Owing to the fact that the exciting (libidinal) and rejecting (anti-libidinal) objects are both cathected by the original ego, these objects carry into repression with them parts of the ego by which they are cathected, leaving the central core of the ego (central ego) unrepressed, but acting as the agent of repression.
- (13) The resulting internal situation is one in which the original ego is split into three egos—a central (conscious) ego attached to the ideal object (ego-ideal), a repressed libidinal ego attached to the exciting (or libidinal) object, and a repressed anti-libidinal ego attached to the rejecting (or antilibidinal) object.
- (14) This internal situation represents a basic schizoid position which is more fundamental than the depressive position described by Melanie Klein.
- (15) The antilibidinal ego, in virtue of its attachment to the rejecting (antilibidinal) object, adopts an uncompromisingly hostile attitude to the libidinal ego, and thus has the effect of powerfully reinforcing the repression of the libidinal ego by the central ego.
- (16) What Freud described as the 'superego' is really a complex structure comprising (a) the ideal object or ego-ideal, (b) the antilibidinal ego, and (c) the rejecting (or antilibidinal) object.
- (17) These considerations form the basis of a theory of the personality conceived in terms of object-relations, in contrast to one conceived in terms of instincts and their vicissitudes.

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OBITUARY

JOAN RIVIERE (1883-1962)¹

I. James Strachey, London

The few, rather disconnected remarks I am proposing to make this evening about Joan Riviere will be of a purely personal kind, and will have nothing to do with her psycho-analytic writings or opinions. They will in fact be no more than a few recollections of the earlyish period of psycho-analysis in London, with which we were both of us a good deal concerned. And I am afraid there is likely to be almost as much about myself as about her.

My acquaintance with her goes back far further than my contact with psycho-analysis—in fact to my undergraduate days at Cambridge. But to explain this I had better start with some account of Joan Verrall's early life. For she was born a Verrall. The Verralls, as some of you may know, were a Sussex family, with many branches, especially in Lewes and Brighton. For several generations, in the late seventeenth and early eighteenth centuries, the branch we are concerned with were what was called 'masters' of a famous Lewes inn—the White Hart, where visitors to Glyndebourne still put up for the night. One of the early eighteenth century Verralls was a bookseller, and another, rather later in the same century, wrote a famous book on cookery, a copy of which in the British Museum belonged to Thomas Gray and is annotated by him. But the really celebrated Verrall was a much more recent figure—A. W. Verrall, the Cambridge classical scholar, who was Joan's Uncle Arthur. He was a truly remarkable person. He had a mind which cut through conventional attitudes and superficial shams in a way which always seemed to me strangely reminiscent of Freud's, and I was amused to find not long ago that Joan Riviere had had the same feeling. I strongly recommend his *Euripides the Rationalist* to any one who enjoys a detective story. He showed, I think convincingly, that the story of the resurrection of Alcestis is a complete fraud and that she was only in a hysterical trance—and that the play

was written in order to bring derision upon the official religious beliefs. But Verrall's theories, too, met with the same fate as Freud's; they were received with complete—if in his case polite—scepticism.

I knew Verrall and his wife quite well when I was at Trinity and used often to go to their Sunday afternoon 'at homes'. And it was on one of these occasions, I like to believe, that I first met Joan, who was a frequent visitor at her uncle's. And this may even have been before her marriage.

She had not herself been to the University, and indeed her education had been a little irregular. She had been sent to Wycombe Abbey and, not surprisingly, failed to fit the atmosphere there; and, as a far wiser alternative, was sent off when she was 17 to spend a whole year at Gotha, and it was then that she gained her command of German, which was to prove so invaluable later on. The next few years were indecisively spent. Her great talents and energies took various directions. She drew, she designed dresses, and for a time worked as a professional dressmaker. When she was 23 she married Evelyn Riviere, himself a Chancery barrister and the son of a famous Royal Academician. It was during these years that I first got to know her. We came out of the same middle-class, professional, cultured, later Victorian, box. And I suppose that contact is always easier between people out of the same box, however much they may have drifted away from it. I still have a vivid visual picture of her standing by the fireplace at an evening party, tall, strikingly handsome, distinguished-looking, and somehow impressive.

It is not known to me how she became interested in psycho-analysis. It may well have been in much the same way as I did myself. Cambridge, and in particular the Verralls, were at that time the centre of the activities of the Society for Psychical Research, which had been started there a generation earlier, mainly by

¹ Contributions to the Memorial Meeting of the British Psycho-Analytical Society, London, 3 October, 1962.

F. W. H. Myers and Henry Sidgwick. I used to read their published proceedings, not because I was much interested in the question of survival, but because that was almost the only place (apart from Janet's works) where I could read anything about abnormal psychology. Soon I became a member, and it was not long after I came down from Cambridge, in 1912, that Freud himself contributed one of his most profound short papers to those very S.P.R. Proceedings. This was my first acquaintance with Freud, and I was immediately fascinated. It seems to me likely that Joan Riviere, who was also connected with the S.P.R. through the Verralls, may have arrived at Freud by the same path. However that may have been, it is certain that she was in analysis with Ernest Jones from about 1915, and that he was handing over patients for her to analyse round about the end of the War, in 1918. It was in 1919 that Jones converted the former London Psycho-Analytical Society into our present one, and Joan Riviere's name appears in the first list of members of the new organization. And very soon after this she must have started off on her work of translating Freud, and particularly the *Introductory Lectures*, which became available over here in German for the first time at the end of the war.

It was just before and during that war that my own interest in psycho-analysis began to become crystallized, and I soon learnt through common acquaintances that Joan Riviere was by way of being an authority on the subject. In 1920 my wife and I went out to Vienna and at once became more directly aware of her activities. For in those days, for reasons of economy, both the *International Journal* (which had just begun to appear) and the *International Psycho-Analytical Library* (which was also just starting) were being printed in Vienna. A young Englishman, Eric Hiller, a member of the British Society, was in charge out there, and we used to help him in the rather desperate work of persuading the Viennese printers to master the peculiarities of English spelling. But we soon realized how much work was being done at the other end by Joan Riviere. The first number of the *Journal* must have come out in July 1920, for I remember having got hold of it just in time to read on the journey to Vienna. And the first number actually contained at its very beginning a paper of Freud's translated by her as well as a short set of clinical notes of her own. You will find her translation of that paper, very slightly changed, in the *Standard Edition*.

It was not till we got back to London, however, after a first year in Vienna—in the summer of 1921—that our actual psycho-analytic contact with her began. This was at a meeting of a decidedly peculiar institution called the Glossary Committee. It met in Ernest Jones's consulting room in Harley Street and consisted of him, Mrs Riviere, my wife, and me. This quite irresponsible body decided for all time how the technical terms of psycho-analysis were to be translated. It is true that some of them had been provisionally laid down already. Ernest Jones tells us that it was Freud himself who suggested 'repression' for 'Verdrängung'. But the Glossary Committee cast a jaundiced eye on many of the versions that had so far been used. And it was at that Committee that the epoch-making introduction was mooted (I must say, rather nervously) of the invented word 'cathexis'—which later became a smash-hit and finally found a place in the large Oxford Dictionary. I must admit that the Glossary Committee disgraced itself lamentably over at least one word. The question was how to translate 'Schaulust'—the pleasure in looking. Greek terminology was all the rage, and the word 'scotophilia' was suggested and accepted with acclamation. It certainly looked a little odd; but nevertheless it passed into all the four volumes of the *Collected Papers* uncriticized. You might have imagined that we should have remembered telescopes and microscopes and so have suspected that the Greek root for looking was something like 'scop'. Actually there is a Greek root 'scopt', but what it means is 'to make fun of'. And so to this day you may still come upon references to the component sexual instinct of pleasure in derision.

By that time Joan Riviere's translation of the *Introductory Lectures* was already in print, and she was already engaged in the even greater undertaking of editing the *Collected Papers*. This was pioneer work, and, though she had assistants, the main brunt of it fell upon her. I must stop here and point out the great good fortune which favoured the early growth of psycho-analysis in English-speaking countries in the emergence of Joan Riviere as a translator. She possessed three invaluable gifts—a thorough knowledge of the German language, a highly accomplished literary style, and a penetrating intellect. Her translation of the *Introductory Lectures* made it possible for the first time for readers of English to realize that Freud was not only a man of science but a master of prose

writing. She set up a new standard which is not easily reached.

We were still in Vienna when early in 1922 she herself came out for analysis with Freud; and it was then that I got to know her better. When we were all back in London we were faced with the frightful work of bringing out the four volumes of the *Collected Papers*. But it is quite wrong to say 'we'. My wife and I did the straightforward job of the case histories. The organizing, translating, or revising other people's translations of the mass of miscellaneous papers in the other three volumes fell entirely on Joan Riviere. This was finally accomplished by 1925, and thereafter her translating activities were mainly devoted to the *Journal*. The only further volumes of Freud which she translated were *The Ego and the Id* and *Civilization and its Discontents*—the title of which, incidentally, is a brilliant proof of her gift for finding the *mot juste*. The later Freud volumes fell into other hands. Hers were in fact sufficiently filled with her *Journal* work. In those early days the greater part of the *Journal* consisted of papers translated from the German *Zeitschrift* and *Imago*. And her function was either to translate these papers herself or to correct the translations made by other and usually inadequate assistants. She was eventually given the rather miserable recompense of being described as the Translation Editor—a post which she occupied till the end of

1937, after which she felt that she might legitimately resign it in order to devote herself to things—clinical work and original writing—which interested her more. Those who knew her will know how time-consuming this *Journal* work was—how all her spare time every evening was devoted to it. But it was in fact the foundation on which all our English knowledge of psycho-analysis was first built.

But I see that with all this I have really said nothing about her. The fact is that notwithstanding our many contacts I really didn't know her very well. Perhaps I was afraid of her. A lot of people were. I often felt sure, for instance, that Ernest Jones was. And indeed she was a very formidable person. I think she rather deplored me and for two rather contrary reasons. One marked thing about her was that in spite of everything she still kept much of her Victorian attitude to life. She disapproved of many things in the modern world—including, I fancy, my distinctly leftish political views. But on the other hand I think she also regretted my non-committal attitude to questions of psycho-analytic theory. Non-committed was a thing she herself could never be. And that I think was, in spite of everything, what was so splendid about her. What she believed she believed; *she* was not afraid. And what she believed she would say, straight out and uncompromisingly. Such courage is a rare and precious thing.

II. Paula Heimann, London

Translator of Freud, founder member of the British Society, pioneer during the heroic epoch of psycho-analysis, training analyst and teacher, author of significant contributions—Joan Riviere was all these, and yet is much less known than would be commensurate with her stature. There are many, even in the British Society, who knew her but little, who have no live picture of her; and she herself, even before her failing health enforced retirement from meetings, often commented sadly on the strange faces in the Society.

The brief obituary notice at the Annual Meeting of the British Society, stating her achievements, mentioned that she combined with her profession a rich private life as wife and mother. From this it might be thought that it was lack of time which accounted for her relative withdrawal.

Time played a part, certainly; it is true that she did not accept as many candidates or patients as is usual for prominent members of the Society. It is true that her manifold cultural gifts and interests stimulated and satisfied, demanded and returned, by her family and friends, consumed time and strength (and physically she was never robust) and imposed restrictions on her ability to take part more prominently in the affairs of our Society. However, lack of time was only one factor. It was something deeply ingrained in her personality that accounts for her relative aloofness. It is my aim to convey something of the person she was, of this rich and rare personality, to bring her nearer to us. Yet my attempt to do this must at this time respect the limits which she set herself.

Since she was profoundly engaged, stimulated and satisfied, in her private life, her professional work did not have to do the double service of giving scope for her scientific abilities and of compensating for lack of private happiness and fulfilment.

Perhaps this fact removed that particular incentive that in the lives of other richly gifted persons makes it attractive to be ambitious, to move in the corridors of power, to start a movement, to seek fame. Freud said in his study on the poet and day-dreaming that ambition ultimately springs from erotic sources, and, following in this vein, we may regard fame as love from the distant many, needed when there is not enough from the few near ones. Thus ambition may make people more forthcoming and ready to offer their gifts more easily to the many. Joan Riviere was not ambitious. She was proud, but she was also humble and shy. The two traits converged to make her shun publicity. Her consulting room and her drawing room were the preferred locale of her activities. To secure priority for her ideas, to have her name floodlit, held no attraction for her. What mattered to her was the cause of psycho-analysis; for this cause she worked, to it she gave, and its furtherance was itself the reward she wanted. She adamantly refused to have her name connected with a donation to our Society, although the donor wished to express appreciation for Joan Riviere's work in this manner. She equally declined the offer of a present on the occasion of her 75th birthday. It is customary for our Society to celebrate special birthdays of its members by giving a collective present. But Joan Riviere did not want this. There were many, she said, who did not know her. It might not be easy for them, financially or emotionally, to contribute to such a collection. Instead she asked for a party, so that those who were in personal contact with her would come just for the sake of social pleasure. In her charming and humorous little talk she expressed the feeling that she had not really done much for our Society, that her merits were small, she had been the receiver and not the giver. And she illustrated these feelings by telling us how, at a party, when she was a little girl, her mother told her she must entertain her guests. So she said she would paint and they could watch her. The gifted mischievous little girl was alive and glowing in the woman of 75. Without relating it in so many words, she painted a vignette of that small scene when her mother disapproved of her

little girl's wish to show off, and we, her guests, could watch with enchantment. We could see her pride in her gifts and in having had a mother who made her humble.

She felt honoured and pleased when asked to speak at the celebrations of Freud's centenary, but she was very unsure about the value of her contribution and very grateful for every acknowledgement.

Shyness of this kind made it difficult for her to speak in the discussions of our meetings, whilst putting a premium on the intimacy of a dialogue. In the small community of two she was a most creative speaker, and produced many bold and original ideas, which she could have expressed in published articles for the benefit of many instead of only one listener. I often urged her to do this, without success. She chose to spend her time and energy much more in helping others to write. Her knowledge, wide experience, and sharp intellect made her a most stimulating partner. She was able to discern not only more clearly what the other person, fumbling for formulation, meant to say, but often she saw much sooner than the other the goal towards which his ideas moved and which they should reach. At the same time she was exceedingly careful in her suggestions and clarifications not to impose on the other, and not to interfere with his specific individual style. She had indeed a very high respect for the individual.

I remember vividly how she once offered me a complete sentence for a draft of mine that expressed my ideas more clearly and carried them a step further. She had taken much trouble to compose it. She offered it to me with the full understanding that I might feel it as alien, and she was not offended when, precisely for the reason she had foreseen, I did not accept it.

While she had almost unlimited patience with people who wanted help with their ideas, she could be very brusque and harsh on other occasions, and she laid herself open to misunderstanding and disappointment. It was not only that she did not bear fools gladly. She expected from others the same concern for the essential and service to a cause that she herself was ready to give, and this made her unwilling to spare people's sensibilities. These she regarded as distracting and petty, and she would not waste time and trouble to avoid treading on people's corns. If it is necessary to walk, you walk, corns or no corns! Thus she could at times appear inexorable in her demands. But it was quite a different matter when she thought

that a person was seriously in need of help. Here from my own experience is one example of many.

At the beginning of the war, she once phoned me to say that she wanted to see me urgently. When she came, it turned out that she believed I might have to suffer from the regulations concerning foreigners. She made me promise that I would contact her immediately should such a case arise. She had influential friends who could help me. This was the first and only time that she made any reference to her connexions with people in power, and it was obvious that she did not like to use human relations for the advantages they might confer. But she was willing to do this in an emergency. I was very glad that it proved unnecessary.

The harshness which I have mentioned diminished greatly in later years. She became able to extract from old age what is beautiful: tolerance and mellowness.

The dominant force in her design of living, the key to her personality, was the striving after beauty, beauty in nature and in man-made things. This need for beauty had nothing in common with precious aestheticism nor with a Hedda Gabler's craving to die in beauty. To Joan Riviere the beautiful was the expression of the life instinct, and it demanded the exertion, the caring, the workmanship, the blood and sweat, the toil and tears that go into the act of creating or discovering beauty. Serendipity had little part in it. She was indeed contemptuous of easy achievements. When I once praised a writer's fluency, she said scornfully: 'Oh, but it is facile'. For herself the style in which she expressed her ideas was extremely important. But where other authors were concerned she distinguished sharply between substance and form, and could appreciate the former even when her sensibilities were offended by the latter.

She sought and found the beautiful in the three areas of life to which she devoted herself: in art, in science, and in human contacts. To her what was beauty in art, was truth in science and love in human relationships.

A common element of the greatest significance to her in these three fields of human experience was that of *caring*: to consider carefully, to pay attention to details, to take trouble, to be thorough, were imperative values to her. She abhorred flightiness, carelessness, and indifference, and seeing these as the constituents of the manic state, the 'manic defence' appeared

to her to represent almost the quintessence of psychopathology, the pure expression of the death instinct. In her article 'A Character Trait of Freud's' (1958) she traced his genius to his capacity to regard whatever he perceived as *valid in itself*, to the fact that 'The impulse to reject and dismiss at first sight was singularly lacking in him'. In Mrs Klein's work, too, it was the careful observation and description of the details of a psychic process, the pursuit of the many contents of unconscious phantasy, that she regarded as the hallmark of creativeness. That she herself was capable of discerning and presenting the fullness of an experience with exquisite clarity and beauty finds expression in all her writings. I will quote a short passage from her paper: 'On the Genesis of Psychical Conflict in Earliest Infancy' (1936), describing infantile aggressive impulses.

'Limbs shall trample, hit and kick; lips, fingers and hands shall suck, twist, pinch; teeth shall bite, gnaw, mangle and cut; mouth shall devour, swallow and "kill" (annihilate); eyes kill by a look, pierce and penetrate; breath and mouth hurt by noise, as the child's own sensitive ears have experienced.'

The artist and the scientist were both at work in her writing. I once commented on the fact that a typewritten page through her corrections looked like a painting. Her lines, dashes, brackets, asterisks, signs of punctuation, and transpositions imparted a beautiful design. She was quite surprised at my remark: to her writing *was* painting.

The sample of Joan Riviere's style which I have just quoted reminds me of my earliest experience with her which made me realize how imperative was the pursuit of the beautiful in her everyday life. We were working together on the German translation of her paper. Time was pressing. She had been working until the early hours of the night. I had come in the morning. As lunchtime approached there was still much to do, and I expected that some sandwiches and coffee would be brought in to avoid interruption. Far from it. It was a Sunday, and her husband was at home. Work was put aside. Joan became the hostess, and I her guest. We all had a delicious meal at a beautifully laid table, followed by a leisurely coffee in her drawing room, talking about many things, but not shop.

I have mentioned her humorous little speech on the occasion of her 75th birthday party. I would like to mention another incident of this

kind. With a delightful twinkle in her eye she showed me a passage in Katherine West's book, *Inner and Outer Circles*, in which the author calls her a 'tall Edwardian beauty with a picture hat and scarlet parasol' and speculates on her lively conversation with a gentleman: 'Perhaps they were discussing theatres or the Post-Impressionists. Or perhaps they were talking about Freud—since this chic and decorative creature Joan Riviere was, of all things, Freud's first translator and a pioneer lay analyst.'

Simple feminine vanity played a part in her life. She enjoyed what in a quite weighty manner she described as an important progress of our time: the improvements in cosmetics, and she used them with pleasure.

Her capacity for enjoyment was wide. She had a hearty appetite for food, in the literal and the metaphorical sense, and in her reading she found delight in her uncle's scholarly research on the Greek classics as well as in the ordeals suffered and inflicted by Mr Hyman Kaplan in his struggles with the English language.

She loved cats and cherished Freud's comments on them. Sewing was an important recreation to her. It symbolized and concretized the creative principle: to bring out in visible form the best possible design inherent in a chosen material.

The seeking after the beautiful in art and science, her style and elegance in a Jane Austen sense, filled her life and shaped her world. Her home bore eloquent witness to this. It always seemed to me that it was not by chance that her husband was a painter's son, not by chance either that he belonged to a profession—the law—which demands the keenest intellect and the most disciplined thinking, and both applied to human affairs.

The principle of dualism, the pairs of opposites, as Freud called it, can be traced in a multitude of manifestations in Joan Riviere's person-

ality. She called herself a rebel, but she was also intensely conservative. She possessed the English reserve to a high degree, but she could abandon herself in enthusiasm. Love for the old and love for the new, for tradition and revolution, for preserving and creating—these antithetical forces often combined with harmony, but also led to conflict.

In two situations tradition won. She could not appreciate the social revolution that took place during the war, ending the class of domestic servants, and felt it as a bitter personal blow that 'nowadays there are only bad servants'. Her life would have been easier had she been able to relax her traditional standards.

As a psycho-analyst she preserved the Freud she knew from personal contact, but did not proceed to his latest theories, thus halting before concepts like the undifferentiated stage, the autonomous ego, and what has developed from them. Her theories treated object-relationship as the 'source and abode' (her phrase when describing Freud's method of writing) of all human endeavour. Yet I have always felt that she was determined by an orientation that went beyond and above human relationships, that she was related to something outside and bigger than any human being. Was this due to her sensitivity to the transience of life? The last message that we received from Joan Riviere told us that there was not to be a funeral: no flowers were to be sent: but whoever wished to pay homage to her should send a subscription to the Leonardo Fund. As we know from the administrators of this fund, her friends' response was significant and generous. She would have been pleased.

Proud and humble she was. Her last contribution was to preserve for her country the possession of an immortal creation of Leonardo's genius; her first, to acquire for her country the immortal creations of the genius of Freud.

III. Lois Munro, London

This tribute to Mrs Riviere comes from one who knew her as a colleague and friend for a few years only. Her frail health in the latter part of her life restricted her from participating in the active life of the Society, and many members were deprived of the stimulating acquaintanceship

with her mind and personality. Her contributions to psycho-analysis in her papers are well-known, but I should like to speak particularly of her contribution to psycho-analysts, especially those who had the good fortune to know her.

Mrs Riviere delighted in her sight and in her

seeing; she valued her sight before all her senses, for it was her eyes which led her to appreciate the world around her and to explore the inner world of the unconscious. She loved looking at beautiful things, visiting art galleries and exhibitions, making excursions as a member of the Georgian Group to see towns and old buildings of merit, houses and their treasures. The countryside was always a source of pleasure and refreshment, and the sight of trees, bare or in leaf, and flowers was a fundamental need in her life. When she was living in Bayswater the flower bed in Hyde Park by Lancaster Gate was her garden where she would choose to walk each day. She had always been fond of walking, knowing intimately and loving the Downs and the Chiltern Hills. Samuel Palmer's paintings and drawings of Sussex made for her a personal statement of the magical feeling she had for that part of England where she was born and grew up. Her vision ranged from the breadth and scope of landscape to the delicate forms of grasses, from the grandeur of architecture to the intricate detail of jewellery and embroidery.

Literature—prose and poetry—was approached through her eyes; she said she made a picture in her mind of what she read, and her visual perception of shape, pattern, and rhythm taught her ears to hear, leading her to the enjoyment of music and intensifying her pleasure in the theatre. Each picture she made in her mind built up a storehouse of memory which was reanimated and enriched by each new experience and which in turn enlivened each new encounter.

People were of absorbing interest. Her gift enabled her to look and to listen in such a way that she gave one the sense of having something worthwhile to say and a companion as concerned with the subject as one was oneself. She needed to know and to understand all that was comprised in any communication, and the phrase 'But I cannot see what you mean' was a frequent expression of hers.

This questing need to see, to know, to understand urged her to explore the mind of man. Her paper, 'The Unconscious Fantasy of an Inner World as Reflected in Examples from English Literature' (1952), shows in the clarity of her exposition that the concept of the Inner World posed no difficulty for her. She recognized the need to bridge the gap between the concept and the conscious mind, and make manifest, to quote her own words, that 'there is no such thing as a single human being, pure and simple,

unmixed with other human beings. Each personality is a world in himself, a company of many'. She rejected nothing of what she saw in the world within; love and hate were the basic constituents of humanity, and their manifestation and interactions engaged her interest completely. It is entirely understandable that psycho-analysis became inevitably and naturally her domain.

Though she was discriminating in the selection and choice of what she herself preferred to have about her and to use, she did not turn her eyes from that which was unpleasing. She scrutinized the ugly as closely as she did the beautiful, and would denounce it forthrightly, giving the reasons for her opinion. Ugliness meant for her dishonesty, falseness, denial, distortion. Her censure of it, her impatient asperity with shoddiness and bad workmanship was no rejecting condemnation, but stemmed from her desire that the desecration of that which was potentially beautiful, a work of art, a truth, should be recognized and made good, should be made whole. To comprehend the whole and to make the whole comprehensible was the challenge she set herself to meet.

Her desire to reproduce for her hearers and readers the beauty, truth, and wholeness of her vision forged her speech and writing to become worthy of her purpose. It is this which makes her papers so satisfying; her theme is expressed so lucidly and developed in beautifully eloquent prose.

At the same time she felt and knew it was not enough to have disclosed her vision, this was but one step of the process; for wholeness could only be furthered by her contribution being given to the outer world, and received by other minds. Here it would inevitably be altered and changed. Equally while new ideas and concepts readily aroused her interest and enthusiasm she subjected them to exhaustive critical analysis before she was convinced of their validity.

Those of her colleagues who met with her for clinical and theoretical discussion will recall the care with which she prepared her material so that the problem she posed was presented without distracting obscurity. In the animated discussion which followed her receptiveness, her ability to set the views of others against her own, to compare, contrast, and evaluate was rewarding to all, and she herself was grateful for the illumination she had gained. One felt such meetings were not only exchanges of views and opinions and the solution of problems, but

openings to wider fields and greater depths which invited further explorations.

Her concept of wholeness then was no static formalized achievement, it had to have movement and change, the quality of aliveness. This could never happen in a vacuum, inside, alone, but only through this cycle of movement from within outwards and back again, altering and changing on the way.

This was vividly shown in her paper 'A Character Trait of Freud's' (1958) given at the end of the public lectures commemorating the centenary of Freud's birth. She succeeded brilliantly in her purpose of portraying the man

in whom the marriage of the scientist and the artist gave to the world a living truth. Over and above this her audience became aware of the creative work of the author herself. They saw how with her sight and psycho-analytical insight in the cycle of interchange between two minds she came to the recognition that the Whole needs for its completeness not only the seeing and the knowing but also the awareness of how strong the *not* seeing and the *not* knowing can be. She gave to her hearers afresh on this occasion as she gave to others the apprehension of that living truth—the un-conscious.

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BOOK REVIEWS

I

The Nonhuman Environment in Normal Development and in Schizophrenia. By Harold F. Searles. (New York: Int. Univ. Press, 1960. Pp. 446. \$7.50.)

In this book Dr Searles discusses the part that the non-human environment plays in the development of the human mind. In the last chapter he reveals his motive for writing on a subject which can involve many different forms of scientific approach to the understanding of the relation between man and his environment. His reason is that as a result of his analytical work on normal and abnormal patients, he holds the view that man has an unconscious, and in some cases conscious, relationship to the non-human environment which is apart from his interpersonal relations.

It can be seen that the hypothesis has immense significance if correct in the sense in which Searles puts it forward. He sees a prospect of finding links between different forms of scientific physical research and such disciplines as anthropology, academic psychology, epidemiology, and psychiatry, if the truth of his hypothesis is accepted and studied. Basically I can see that an important branch of such research would be the study of the direction in which evolution is moving, and also the problem of the relationship between man's physical and mental processes.

In his introductory chapter he writes of primitive man's relatedness to his environment, which was dominated by animism and lack of differentiation from the environment. He contrasts this primitive attitude with that of the psycho-analyst who focuses attention on intra-personal and interpersonal relationships. The reader is reminded that Freud did not ignore the biological evolution of man, and described the totemism of primitive man and the child's relationship to the animal father (the horse), but he holds the view that Freud did not attribute full significance to the *persistence* of the non-human factor in man's psychological life.

In speaking of psycho-analysis Searles points out that recent work on ego development has already made observations pertinent to his thesis. He mentions a number of analysts,

including Hartmann, Rapaport, Winnicott, and Mahler. In the chapter on the non-human environment and the healthy individual many illustrations are given of intimate relationships between man and a favourite animal, and man in contact with nature, the sea, the land, the garden, etc., and in some cases the development of a mystical relationship. No one would dispute the truth of these observations, and they are frequently taken for granted, possibly without a full recognition of their psychical significance.

An important contention and original contribution is the suggestion that some cases of neurosis and psychosis reveal the wish to be non-human. It has of course been recorded by many analysts that an unsettled home in childhood increases the child's anxiety and therefore influences the psychic development, but the interpretation is usually regarded in terms of mother-failure, not in terms of the loss of a house or other loved non-human possession. The evidence presented by Searles is convincing, and the idea that man in certain circumstances can wish to be non-human may be compared to Freud's theory of the death instinct as a wish to return to an inorganic state.

I have had a patient who produced a paradoxical situation which could be interpreted as showing the wish to be non-human and yet to deny the death wish. She was an unmarried woman of 45 whose mother and sister were schizophrenic, and her childish experiences included a continual change of home every few years, owing to the parents' inability to settle in a home. Her phantasy was about beautiful old houses, and she would visit any that she heard of. The only solution to her problems, she said, was death; yet she was sure she would live to be very old. Sleep was also a mode of escape. The determination of the death-wish was complicated, but she was not suicidal or typically depressed, and physically she was healthy and intelligent. She illustrated Searles's description of a 'warped conception of herself', as she had no belief in her personal identity and capacity to be a person and to succeed. The clinical material which Searles presents is full of interest, but possibly the quantity of it and the repetition

in the material may prevent some readers from fully appreciating its value, which is great.

The description of the patient who is compelled to treat the analyst as non-human is of interest. I have had two patients who presented this type of resistance and whom I allowed to confine the analytical hour for a time to their own contributions. It was obvious that my presence was essential but I was not a human being in my own right. I think that the interpretation of this situation can be that given by Searles, or possibly that the analyst had been incorporated and was functioning internally.

In the last two chapters the author deals directly with the influence of modern culture and the advance of abstract knowledge such as physics and chemistry on man's mental equilibrium. It has already been shown that the schizophrenic regards a new machine as a dangerous attacking enemy. The radio when first invented was felt to be particularly menacing. Searles suggests that the advance of technical and mechanical knowledge resulting in the invention of new machines that act instead of man introduce psychical problems of adaptation which would be better understood and dealt with if the full significance of man's non-human dependences was recognized and understood.

In other words it is necessary to recognize man's reluctance to abandon his unconscious non-human relationships before he can develop a secure personal identity which enables him to adapt to the non-human objects of the present day.

Sylvia M. Payne.

II

Ideas, like the Word, can fall on stony ground, or they can be received into good soil and so bear fruit. An original idea needs an audience, and the good audience consists of those who have already had the idea; they are glad to find it formulated, and they are angry, too, that a chance for claiming priority has been missed. Thus, originality is tricky to assess and to attribute, and each originator is to some extent a copyist.

I like to be part of the audience, part of the good soil that makes this work of Searles bear fruit. The idea of a study of the non-human environment is a sound one, and long overdue in psycho-analytic circles. Searles discusses why it is that there has been this long delay, and indeed analysts may be expected to become suspicious of any trend that diverts attention

from the theory of object relationships, the object being human, or a part-object waiting to be allowed to become whole. This suspicion comes from the development of psycho-analytic theory on the basis of the id contained by the ego and controlled by the superego, or of the ego oriented both to the id and to external reality and permanently engaged in reconciling these two realities. When psycho-analysts became secure enough to explore ego-psychology and ego-relatedness, then new insight was gained both into the meaning of infantile dependence and also into the needs of those schizophrenic patients who carry along with their illness a tendency towards healthy though delayed emotional development.

Searles has made a whole book, and a very interesting one, out of this subject of man's relationship to the non-human environment—to the dog as a dog, apart from its symbolism, and to the physical world apart from its meaning as mother, or as a place for taking projections. One could perhaps say that when Sechehaye gave that apple to that girl at that particular moment (symbolic realization) Searles draws our attention to the fact of the apple, which presumably was suitably ripe, and also to the orchards from which apples come, and to Sechehaye's access to the products of orchards, and so on.

Certainly this theme develops very easily once consideration of it has been started, and even if the idea underlying what is written can be taken out and looked at here, it is the actual reading of the book that will reward the reader.

In regard to the idea, much of my own work has been related to this theme. I have had no fear that the theory of individual development will be interfered with by recognition of the part played by the environment outside the area of the individual's projections. One is reminded here of Hartmann's conflict-free area in the ego, which in no way interferes with the concept of conflict and anxiety.

It might be found that Searles' non-human environment comes round in the end to being the mother, but in a way that is different from the usual way by which environmental phenomena are seen as projections, and projections of introjections. I mean that this non-human environment may be looked at as an extension of the environment that is the mother, prior to the baby's arrival at object relationships with id cathexes. I have developed this theme in terms of ego-relatedness, and in terms of double

dependence. By double dependence I mean the relationship of the infant to environmental phenomena of which the baby could not possibly be aware, so that later as a patient the baby now grown to childhood or adulthood is not able to reproduce it as a pattern revealing itself in an analytic transference. In other words, the environment to which I refer in the concept of double dependence is one that is essentially not made up of projections. Later the individual may reach to a recognition of this in a sophisticated acceptance of 'shared' reality. This acceptance of the reality principle is a matter of the intellect.

So some of the non-human environment of Searles is human, some is animal, some is vegetable, and some is purely physical. The force of gravity is an element of the non-human environment that distinguishes the period after birth from the prenatal period; on the positive side the infant knows this in the sensation of feeling heavy, and on the negative side the infant knows of gravity indirectly through the infinite panic associated with being held in an unreliable way. It took a Newton and thousands of years of sophistication for the concept of gravity to be formulated, and all the time in observation of developing babies we see the effects of non-human environment details, often never achieving the status of statement. Searles is attempting, I feel, to make a generalized statement, one that covers future developments, as for instance the possibility that one day psychology might contribute to physics in regard to some detail.

Would Searles agree to a change of name? It seems that his term is not good enough because his non-human environment may well be human, such as the colour of the mother's hair, the fact of her survival or death, or the profession of the father, who may be a miner and come home black, or a baker and come home white. I think Searles is referring to the non-projective environment, or all those aspects of the individual's environment that in fact take effect or impinge before the individual baby is ready to gain control of external reality by the mechanisms of projection and introjection.

The affinity between Searles' point of view and my own can be easily illustrated. For instance (p. 416) 'The deeply regressed patient, more than any one else except for the infant, needs to have a non-human environment which is not only relatively stable and relatively uncomplex, but also beautiful'. Leaving out the detail of beauty,

which introduces more complex considerations, I find this idea of a relatively stable and relatively uncomplex non-human environment almost the same as my own insistence on the good-enough mothering without which the development that makes for mental health (in the sense of non-liability to psychosis) cannot take place satisfactorily. This is the non-human environment which is in effect the mother, the mother and father, the family, the place, affecting the baby before the era of control by projection and introjection.

The early oneness of the stage before the baby separates off the mother from the self, that which appears in psychotic illness as a merging, is a oneness not with a person, nor with an object; it is a oneness with the non-human environment, or, as I would like to call it, a non-projective environment. In this way Searles' study is of great importance both for the understanding of the needs of schizophrenics and also of the phenomena that are silently at work in ordinary good-enough mothering.

Searles may, however, prefer to stick to his term non-human environment and so to concentrate on referring to the fact that in the process of getting to control external reality by introjection and projection the developing infant (or regressed patient) is dependent on what external reality does in fact exist for use in the exercise of these mental mechanisms.

D. W. Winnicott.

Ego and Body Ego: Contributions to their Psychoanalytic Psychology. Robert Fliess. Psychoanalytic Series, Vol. II. (New York: Schulte, 1961. Pp. xv + 390. \$9.00.)

I

In his foreword to this second volume of a projected trilogy of monographs on psychoanalytic research, Fliess, anticipating possible criticism, concedes that the title he has chosen 'is likely to arouse expectations it cannot fulfil'. Feeling perhaps a shade penitent, he goes on to shrive himself with the reflection that it is 'impossible to furnish a systematic description of either ego or body-ego: our knowledge is insufficient'. This self-administered absolution should be read in conjunction with a comment to be found on the next page, where *à propos* what he claims to be a 'metapsychological innovation', namely his concept of 'demi-institutions' in the ego proper, he cheerfully admits that he has disregarded 'most of the

present literature on the ego, in which I found little of profit'. Viewing the volume as a whole there seems to be some ground for the conclusion that Fliess has sought to make good this seeming deficiency by burying his central hypothesis regarding the 'pleasure-physiologic body ego' in a compost of theoretical and clinical contributions which, although, at first reading, apparently irrelevant to his main preoccupation, may well have provided him with a substrate of clinical and metapsychological concepts on which to rest his hypotheses. But whatever may be the explanation of an apparently purposive disorder (it would perhaps be better to say circumlocution) in presentation, it is a tribute to the stimulating character of the book to say that the psycho-analytic student will find it worth while to quarry in it for thought-provoking if frequently controversial ideas.

The introductory chapter on psycho-analytic technique need not however detain the reader very long. Apart from passing references to the resistance brought about by an 'ego-split' between his two 'demi-institutions', and to the improvement in interpretation that can be achieved by a full understanding of the body-ego, it has little reference to the central topics of the book. To be sure, one is tempted to sidetrack oneself by a discussion of his concept of resistance by 'hypnotic evasion'. But as hypnosis is to be dealt with in his third volume, we may in the meantime resist the temptation to correlate transference reactions with varying degrees of suggestibility.

In the following section on the 'mother-child unit', Fliess, who has evidently been profoundly impressed by Mahler's papers on child psychosis, provides a running commentary on her conclusions drawn from his observations of neurotic adults brought up respectively by 'autistic', 'asymbiotic', and 'hypersymbiotic' psychotic mothers. To be quite fair, and allowing for the author's evident taste for metapsychological neologisms, to say nothing of his relish for the unravelling of overdeterminations, he does in this section give the reader some clues concerning his views on ego structure, as where he describes severe distortions of the ego and body-ego or body image induced in their children by 'asymbiotic' and 'hypersymbiotic' mothers.

After this preamble, Fliess begins to get down to his subject. He describes 'a further differentiating grade in the ego' and presents his hypothesis of two 'demi-institutions' in the ego

proper. Here the reader will find his patience and assiduity severely taxed in extracting from a copious mass of involved argument and equally involved clinical interpretation the metapsychological gist of Fliess's presentation. Briefly, the ego in which he finds his differentiations is a mental institution in the narrower sense, to be set alongside the superego and id systems. In this ego-institution, Fliess maintains, two parts can be observed during the study of morbid conditions, such for example as depersonalization, more frequently morbid self-observation, inhibitions, etc. One part (the 'myself') is the 'partial subject' (of certain instinctual strivings) and as far as the body-ego is concerned centres round an erogenic zone; the other (the 'I') he terms the 'introject', which is complementary to the 'partial subject' 'erected by means of (secondary) identifications with "later" parents'. It is 'that part of the ego which is representative of the group'. The 'partial subject' is essentially 'the exponent of sexuality and (or) aggression'; it is 'close to and serving the id'; whereas the introject is essentially the exponent of aggression defused; it binds aggression and in the case of a 'split' directs it against the 'partial subject'. 'It is close to and serving the superego'; the personal representative in the ego of an object. The two 'demi-institutions' occur earlier in ego-development than the establishment of the superego; they are 'original with the second anal phase'; it is, Fliess says, 'in the continent second phase that one can for the first time oppose an introject to the "partial subject"'. Both can be represented in the body-ego; indeed interference with their interaction can disturb reality-testing, and result in a defective body-ego. Finally, for there must be an end to excerpts, both parts can be unconscious.

At this point the reader would be well advised to skip for the time being the intervening clinical sections on the neuroses and on the concept of time, and proceed forthwith to the section (chap. iii, part 2) 'on the pleasure-physiologic body-ego'. In an all too brief introduction on the body-ego proper, Fliess defines the latter as the 'sum total of our organ representations'. Body ego and ego are not the same. 'The former is but an important part or aspect of the latter; it could in certain respects even be called its core.' Psychically speaking it is 'pre-conscious', its parts being 'in a perpetual state of oscillation between being descriptively unconscious and becoming descriptively conscious'. The normal

body-ego must be studied by neurology—Gestalt psychology and analysis (not psycho-analysis) of the senses. Psycho-analysis is however the one and only method of studying one aspect of the body-ego, namely, 'the pleasure-physiologic body-ego'.

Here Fliess himself finds the task of definition difficult. He would like to call it 'the totality of the erogenic zones and ascribe its influence upon the body-ego to erogenic processes.' But as the erogenic zones can be partly or totally displaced to other parts of the body which *ipso facto* become erogenic themselves, the result is 'an inconstant, often bewildering, overlapping of the pleasure-physiologic body ego and body-ego proper'. 'At the core of an element of the pleasure-physiologic body ego is an erogenic zone, either undisplaced or displaced. Its pleasure-physiologic function, inseparable from the element proper, is therefore in the last analysis either excretory or ingestive.' It is established 'with the assistance of primary and of secondary identifications'; 'it is ego but much of the functionings in it nevertheless obey laws of the primary process'; 'it may ever so often co-opt, as it were, parts of the body-ego auxiliary to its function'. The element in question has expanded 'to the extent of becoming a partial subject'.

But no amount of quotation can either convey the gist of this anfractuous book or reduce the confusions to which it may give rise in the mind of the student. Like many writers on the theory of psycho-analysis, Fliess is manifestly concerned to delineate the structure of mind during the earlier pregenital phases, to isolate different parts of it, and to relate these on the one hand to earlier experiences of libidinal and aggressive tensions, and on the other to the activities of 'later' psychic institutions such as the superego. In so doing he is caught between two structural images, which are not particularly congruous—on the one hand he dallies with the concept of 'cores', presumably arranged concentrically; on the other he emphasizes a simple dichotomy in the ego proper which antedates the development of the major dichotomy of ego and superego, a 'transversal' split (which however under normal circumstances is to be regarded as a 'division' rather than a 'split') and can usually be distinguished from the longitudinal splits attributed by Freud to unduly intense and mutually incompatible object identifications.

The implications of this second and more rigid system of differentiation can better be

grasped by considering Fliess's choice of the term 'demi-institution'. Choosing this caption the author would seem to have been 'working backward' from Freud's derivation of the superego from the abandonment of incestuous strivings together with the introjection of the frustrating parental images: whereas in the case of his concept of the 'pleasure-physiologic body-ego' Fliess is clearly 'working forward', that is to say, starting from immediate post-natal life in an endeavour to isolate the component parts of the body-ego, ultimately of the ego proper. Perhaps some of the confusion in his presentation arises from the author's attempt to make these products of speculative reconstruction link with the clinical facts of a much later period, always a hazardous enterprise and usually doomed to inaccuracy.

In any case, why canonize the term 'demi'-institution, which merely implies that a hypothetical ego-proper comes to be composed of two parts? Had the author followed his own hunch about 'cores' and linked this with the concepts of component sexuality and the components of aggression appropriate to a progression of instinctual priorities, he would almost certainly have shed more light on the problems of dissociation than he does by the simplistic device of bisecting the ego proper.

The explanation can scarcely escape the reader, namely, that working back from the later differentiation of a superego Fliess cannot come to terms with *component* sexuality and component sadism (or masochism) and applies Freud's superego formula to what he (Fliess) clearly regards as the 'pre-superego'. In simple terms Fliess is engaged in the familiar task of isolating 'fore-stages' in the development of the superego differentiation. Indeed, if it were not for his use of special terms (neologisms) it would be difficult for the reader to detect any distinction between his 'partial subject—introject' antithesis and Freud's own description of the antithesis arising from superego formation.

A similar train of thought is stimulated when examining the author's concept of the 'pleasure-physiologic body-ego'. For although Fliess freely admits the existence of overlappings, mergings, and expansions as between the 'pleasure-physiologic body-ego' and the body-ego proper, he still maintains that the distinction is essential, indeed that whereas the body-ego is refractory to psycho-analysis, the 'pleasure-physiologic body-ego' can be investigated only by psycho-analytic techniques. What the

author fails to do is to set down clear and comprehensible definitions by means of which working distinctions can be drawn between the two concepts. To be sure, he has expressly abstained from any attempt at systematic description, but he cannot be surprised if the price of this disclaimer should prove to be haziness and confusion.

This criticism by no means implies that Fliess is not prepared to expand his own conception of the 'pleasure-physiologic body-ego'. On the contrary he employs every metapsychological device to extend his main proposition. Of these perhaps the most confusing concerns the differentiation of unconscious, preconscious, and conscious mental systems and the influence of mechanisms such as 'introjection and identification' on the 'pleasure-physiologic body-ego' and on the 'partial subject'. The 'pleasure-physiologic body-ego', Fliess maintains, is a preconscious element in mental life: yet the mechanisms concerned illustrate the operation of 'primary processes'. On the other hand the processes of primary and secondary identification play an important part in its formation, a circumstance which can lead (i.e. through identification) to the development of a 'partial subject' demi-institution. Not only so, this common point provides a 'site of entry' for introjected objects.

Now there can be no doubt that the deeper layers of the preconscious can represent transitional phases in the passage from 'primary' to 'secondary processes', but it only confuses the situation to extend this to a wholly preconscious 'pleasure-physiologic body-ego'. The older distinction of unconscious from preconscious levels depended on dynamic criteria that could be measured to some extent by the strength of the mechanisms which have to be overcome before unconscious content is capable of entering the preconscious. Granted that, as Freud suggested, not all parts of the unconscious ego and superego systems are necessarily governed by primary processes, it does not follow that the preconscious proper is a seat of primary processes. Such a view would involve a recasting of classical teachings regarding symptom formation.

With regard to the relations of introjection and identification, Fliess is apparently content with the simple view that identification is 'based on' introjection. It is at this point that one regrets the author's decision to discount the existing literature on the ego. For clearly there

is as yet no consensus of opinion on the vexed question of the distinction between these two mental mechanisms and the criteria by which they can be distinguished. In any case anthropomorphic (structural) images such as 'sites of entry', although useful for purposes of classroom presentation, are not strictly speaking adapted to the scientific description of psychic mechanisms.

In the province of psychological reviewing enough is better than a feast. To do justice to Fliess's compendious book would involve writing a critique equally compendious, and that course would be justified only if his conclusions and innovations promised adequate recompense—in this case an open question. What does stand out after immersing oneself in his metapsychology is the root problem of the psycho-analytical metapsychologist, viz. how to manipulate his basic working concepts with an eye to the maximum understanding of data. Indeed one might well lay down the rule that when any one approach to mental phenomena gives rise to difficulty (puts a strain on the imagination) it is high time the author shifted his ground and canvassed an ancillary approach. When, for example, a structural formulation begins to creak, it is high time the author changed his idiom (set of analogies) and regarded the position from the point of view of economics in general and defence mechanisms in particular. The reason so many metapsychologists neglect to do so is no doubt subjective, a preference, for example, for structural as against dynamic and economic approaches. The fact that certain mechanisms (introjection, identification, and reaction formation) are very obviously pattern forming (in the ego sense) and certain others (projection, repression, etc.) are not, gives rise in them to the temptation to explain mental phenomena on a structural rather than a dynamic basis. It is so much easier to anthropomorphize the ego, thereby repeating the mistake made by every child in course of mental development.

To this it may be added that every theoretician should make a practice of summarizing his own metapsychological credos before embarking on fresh presentations (innovations). Study of this book shows that on the whole Fliess has been concerned to preserve as many standard Freudian approaches as possible, in particular seeking to combine Freud's earlier delineation of the mental apparatus (as set out in *The Interpretation of Dreams*) with his later and mainly

structural ventures. He has also endeavoured to preserve as much as possible of the classical Freudian concept of phases of libidinal development, adding at the same time these more recent amplifications of the history of the aggressive impulses which seem to have hypnotized most modern contributors. This works out well enough when dealing with mental development at the period of maximal oedipal attachment, but it does not help so much in the case of the pregenital development of mind. The further back one pushes speculation (for the bulk of early reconstruction is speculative), the more one is faced with the manifestations of an energetic flux. Instinctual flux, mechanism and structural deposit is the logical sequence to be followed when reconstructing early psychic phases; and every attempt to describe the mental apparatus in these hypothetical stages should be as free as possible from the bias introduced by 'working backwards' (a pseudo-scientific device of the same order as the analysand's 'ruckphantasieren') carrying in so doing working concepts which, however valid they may be for later stages, are not appropriate to the description of the earliest phases. Fliess, for example, is so carried away by the desire to correlate the development of 'demi-institutions' with the second anal phase, that he lends his authority to the suggestion (made by Beatrice Enson) that young mothers should delay toilet training until the child has 'achieved a firm and consistent mastery of the use of "I"'. To say the least of it he might well have qualified this sweeping recommendation, which takes little cognizance of variations in ego-development, with the rider that the necessity for a set toilet training is an obsession that some analysts share with 'asymbiotic' and 'hyper-symbiotic' mothers.

But when all is said the student has good reason to be grateful to Fliess. For whatever we may think of his theoretical 'innovations', his book contains a plentiful supply of clinical instances together with a running fire of interpretations which should encourage psycho-analytical readers to 'play' freely with the associative data they collect during analysis. Even if they do not always agree with Fliess's interpretations and correlations, they have at least ample opportunity of studying the technique by which mental content and behaviour can be manipulated and, often in accordance with the preconceptions and hunches of the observer, assessed.

Edward Glover.

II

This book is the second in a series by Fliess in which he expands and further develops the personal theories initially suggested in his first volume. Justice cannot be done to his complex and highly stimulating hypotheses in a condensed version. As the author himself implies, they demand careful study and thoughtful consideration. In many instances he gives terms a particular meaning which differs from the usage generally accepted. The reader must also keep in mind the statement on page xiv of the foreword, 'I disregard most of the present literature on the ego, in which I found little of profit'.

Interspersed throughout the book's theoretical presentation are many pithy, astute clinical observations which reflect the author's clinical experience, sharp attention to details, and readiness to recognize new meanings in previously described symptoms.

The volume is introduced by an addendum to psycho-analytic technique. Amongst several points, the author declares that 'side by side with transference and equal to it in importance, exists projection upon the analyst'. Thus transference is object-libidinal, whereas projection is narcissistic. Fliess therefore calls the result of projection a delusion about the analyst. By so doing he attempts to explain the transient gross distortions of reality seen in clinical practice. He recommends that the analyst be not blinded when the patient labels the 'delusions' fantasies or implies he has insight.

He supports his argument with Freud's words that the neurotic does not replace reality but simply 'does not want to know about it'. However, does this offer advantages over the idea of transient regression during the analytic hour?—an occurrence which is made possible because of the support offered by the positive transference. Furthermore, would not the definition of a delusion require an alteration, since the idea of a fixed idea that does not respond to logic is an integral part of a delusion?—though I agree there may be a need for a term for those ideas of neurotic symptomatology which do not fit into the usual categories. To designate them as delusional seems unfortunate. Fliess cites a patient who bolted from the office because 'the silence caused her to feel "slashed" as if by a "bayonet"'. The evidence that it was delusional is her bolting from the office. However, she did return, and did not expect him to slash her. For most readers, I believe this action would be

regarded as an expression of a libidinal transference, and that the patient feared her own incestuous wishes transferred to the analyst.

The author disagrees with other writers on the subject of counter-transference, and wants the term restricted to a condition denoting only a disturbance in the relationship of analyst to patient. Again he offers a provocative thought when he emphasizes that counter-identification with the patient provides the most serious problem, but calls these reactions delusions on the part of the analyst.

Another technical point of the author is his belief that the analyst generally has an unwillingness to accept the concept of ambulatory schizophrenia because he is not prepared for the inhuman neglect and excessive abuse which his patient relates or can be induced to tell him about. He goes on to say that credence is not given to patients' reports and that analysts do not obtain sufficient amnesia-removal to become acquainted with the abuse. Such comments impugn most analysts, who do not report the same findings or give them the same interpretations. This problem is further discussed in the chapter devoted to the Mother-Child Unit.

In this chapter (p. 73 fn.) Fliess states "most college girls have no difficulty in using Tampax, although they may as yet not have consorted with a man; I am inclined to believe that more of them are possessed of hypersymbiotic mothers than of an unusually large opening of the hymen". Though Fliess states that he is referring to severely disturbed patients having psychotic mothers, he implies that a very high percentage of mothers of patients are psychotic. The reference to the college girls and to a social study supports this impression. It might have been better if his personal definition of psychosis had been presented, since the reader is obliged to believe that parents who neglect, abuse, and seduce their children must necessarily be diagnosed as psychotic. Fliess offers a great many data from patients in whom he uncovered histories of gross sexual abuse by their mothers. It is not easy to assume that only his patients endured such experiences. Were his patients an unusual series, or is his contention correct—that other analysts have a resistance to uncovering such histories? It would have been useful if outside confirmatory evidence had been presented to the reader to dispel the possibility of retrospective falsification or fantasies of seduction which Freud originally recognized as such. A typical detailed clinical history would have been valu-

able, though one is aware of the need for the patient's anonymity.

The foregoing only reflects criticism of Fliess's otherwise brilliant effort to correlate the analysis of a psychotic child with his observations during the analysis of an adult. He attempts a detailed comparison between Mahler's description of an autistic child and an adult's history. His starting period is Mahler's work with autistic and symbiotic infantile psychoses. He emphasizes that neither is brought about by influences from the environment. He coins the term *asymbiotic* for the mother whose relationship to the child breaks down, not on the first day of the child's existence, but only in the symbiotic phase, around 1½ years of age.

He presents comparisons between the child reported by Mahler and his adult patients, symptom by symptom. He cites parallels between Mahler's description of the autistic child as unable to cope with diversified stimulation coming from the outside world to specific detailed symptoms such as bowel activity, vomiting, and her theoretical statement that 'there did not seem to exist any clear-cut differentiation between the actual object and the mental representation of it'. From these minutiae he describes transitive phenomena and distortions of the body image wrought by the hypersymbiotic mother.

In chapter two he presents a hypothesis of two institutions in the ego. He calls them two *demi-institutions*, to contrast them with the 'institutions' described by Freud. The goal is to help explain the ego's functioning, and in particular, I believe, the part of the ego which is influenced by later experiences, and that part which executes discharge phenomena and to offer a better theoretical understanding of certain clinical problems. He calls the one a 'partial subject', and offers it as the subject of certain institutional strivings which may or may not be genital. They can be instinct derivatives, and as far as the body ego is concerned it is centred around an erogenic zone. The partial subject is ego, but close to and serving the id.

The other *demi-institution* he has designated the 'introject', and he defines it as that part of the ego complementary to the partial subject. (Since the word 'introject' has already acquired its own specific meanings, the choice may be questioned). It—the introject—is erected by secondary identifications with 'later parents', and he also suggests it could be called 'the representative in the ego group'. The partial

subject is essentially the exponent of sexuality and/or aggression; the introject, that of aggression more or less completely defused. Normally, there is only a 'line of cleavage', but with a morbid process there is a 'split' between them.

The division of the ego into the two demi-institutions occurs earlier in the course of ego development than the development of the superego, during the second anal phase. The introject is established out of secondary identification. Fliess believes that his theory gives a metapsychological explanation of the distinction between identification with the father and the choice of the father as an object. He then presents a clear example of a child's need to develop a concept of himself before acquiring continence. A detailed diary is presented revealing the child's difficulties before his ability to refer properly to himself. Bowel control occurs only after he can use 'I' accurately. This is proffered as further evidence of secondary identification. The partial subject enjoys the defecation, whereas the introject effects an inhibitory delay, which is in compliance with the demands both of later parents and the group.

Whereas critical observations are made by the superego, the introject makes self-observations. Thus projection by the introject may lead to delusion formation. Likewise the introject may inhibit without disapproval. At another point the author remarks that Freud's split in the ego may be called longitudinal, whereas his own may be considered transversal. Just what this means is difficult to say without some points of reference for what is vertical and what is horizontal. The theory of the demi-institutions is then applied to many psycho-analytic problems. For instance, the 'consummation of identity consists in innumerable observations by the introject of the partial subject, whereby the latter impresses itself as it were upon the former' (p. 112). This means a normal 'division' which permits an exchange of cathectic energy between the institutions. The inhibition of affect arises when the introject itself appears directly to the partial subject and so prevents it from elaborating upon the drives and producing affect.

The theory is then applied to several clinical problems. Fliess discusses the various aspects of a compulsion within the framework of his theory, and believes they cannot be understood otherwise. For instance, he says that the role of the ego can only be understood with the help of the hypothesis of the two demi-institutions and the split as he describes it. Thus he says that

the 'taking sides of the ego in the conflict between the superego and id' is reduced to a cathectic reorientation between introject and partial subject. From here he goes on to discuss conversion and phobias.

The richness, erudition, and penetrating thinking revealed by Fliess cannot be communicated in a brief summary. His theory has an appealing quality in that it gives further elucidation and more direct representation of the many problems that confront the analyst and which have not been suitably explained. However, a theory of the ego which totally disregards all modern concepts of ego function is difficult to accept fully. Though an effort is made to present the new concept as dynamic, one gains the impression of rigid organization or institutions. Likewise it seems to blur the idea of the ego as a structure with a synthesizing function, as an executive instrument, or as mediating between the id and the superego. The role of the superego is carefully distinguished from the introject. However, in the clinical examples it would be possible to apply concepts of a harsh superego on a benign superego to understand them. At times it becomes difficult for the reader to distinguish between the superego and the introject. Is the invention necessary? Is it not possible to conceive of the ego and superego as being affected by experiences before the passing of the oedipal complex without theorizing new structures?

Chapter three is devoted to the author's concept of Pleasure-Physiological Body-Ego. In the foreword this is defined as 'a preconscious psychic formation dominated by the primary process and reflecting the body as far as the latter is libidinal or libidized in the mind'. It is the one aspect of the body ego suitable for study by psycho-analysis. He then states 'an element of the pleasure-physiologic body-ego is, in fact, the illusory representation in the mind not of an organ but of a combination of organs; and the function of this combination is not divorceable from the combination itself'. This may be regressive, since discharge or inhibition of discharge of libido that has persisted since childhood, or there may be fantastic elaboration upon certain anatomical parts. To my understanding it seems to rest ultimately with the erogenous zones. It is established with the assistance of primary and secondary identifications.

From his clinical example it is difficult to ascertain the advantage of this concept over

recognition that successful analysis removed conflict and thus permitted a libidinal gratification. When he says it is a part of the ego obeying the laws of the primary process we are at first inclined to agree that it helps to explain some of what we see in patients, such as displacements. However, I cannot place this within the ego without rending asunder the concept of the ego. That part of the ego and superego is unconscious hardly supports this idea. I see no advantage in shifting the primary process to the ego. This theory is applied to identification, minimization, and magnification and projection. The clinical discussions are superb, but are obfuscated for me by his use of the pleasure-physiologic body-ego conception.

There is a fascinating discussion of *Hamlet*, in which Fliess presents evidence for a passive Oedipus complex. He adduces evidence to demonstrate that Hamlet was able to kill his uncle at the height of his mother identification. In a brilliant analysis he demonstrates the use of primary process by Shakespeare (p. 290 ff.)

In an addendum to Volume I several other ideas are proposed, such as the existence of a primal hate against the older brother.

Another hypothesis is refractory narcissism. This is defined as that libido which lends itself to cathexis of an object and does not become transformed into object libido. In his examples a child is used by an adult for direct sexual gratification.

It is the author's contention that when 'someone employs an object as a symbol for an element in his pleasure-psychologic body-ego he cathects this object with narcissistic libido'.

In another paper the author presents his disagreement with Freud's description of the castration complex in women. In particular he questions Freud's statement that 'we can hardly speak with propriety of castration anxiety when castration has already taken place'. In essence his point is summarized in the statement 'It is the genital of the phallic mother that has in the deepest layer of the unconscious eventually replaced the child's phallus, which is owned and lost as is the mother herself; until eventually the phobic avoidance of showing it, meant to insure its possession, maintains only the fear of its loss, i.e. the fear of castration'. Does this fully explain the difference between an anatomically present phallus being endangered and one that is not physically present?

It is necessary to reiterate that Fliess's original thinking cannot be properly presented in an

edited or condensed version. Detailed study is requisite for its understanding. Interspersed throughout the book are clinical psycho-analytic gems which are not casually referred to. Unhappily, at times, the tone of the book suggests that he is addressing analysts who are ill-informed, who have not read Freud, and a note of condescension creeps in.

Sylvan Keiser

Mohave Ethnopsychiatry and Suicide: The Psychiatric Knowledge and the Psychic Disturbances of an Indian Tribe. By George Devereux. (Washington: U.S. Government. Bureau of American Ethnology. Bulletin 175. 1961. Pp. 586. \$3.25.)

This massive study of the psychiatric beliefs and practices and the incidence of psychopathology in a small tribe of Colorado River Indians not only crowns the quarter of a century of work which Devereux has put into the study of this tribe; it is also an important landmark in the development of the social sciences. For the first time, to the best of my knowledge, technical social anthropology and a sophisticated psycho-analytical technique have been used simultaneously without the one set of concepts dominating the other. This is not merely an anthropological field-study illuminated by the author's psycho-analytic knowledge, nor is it the application of psycho-analytic insights to exotic 'primitive' material (as was the case with the late Géza Róheim's work, for example); the two disciplines are used concurrently, with no ambiguity about which frame of reference is being employed in any portion of the text. It is perhaps relevant that, as Devereux tells us, the greatest part of the data were gathered between 1932 and 1938, during three extended field-trips, when he was not only ignorant of the concepts of psycho-analysis but hoped to use his material (as Malinowski had done earlier) to question the basic postulates of psycho-analysis: 'the congruence of my Mohave data with psycho-analysis is not the result of a pre-existing bias. On the contrary, it was my dawning awareness of this congruence that caused me to become interested in psycho-analysis in the first place'. As a practising psycho-analyst, with a lively interest in theoretical concepts, Devereux has reinterpreted the material he gathered by the rigorous following of the techniques of social anthropology; but he also presents the bulk of these data in the form of prolonged interviews, dated field-notes with identified informants,

and the other precisions of anthropological monographs. A reader could accept his data without necessarily accepting his conclusions; and material presented in this way is a basic requisite for the scientific development of our knowledge of human beings and human societies.

The book is also singular, if not unique, in presenting a non-European, 'primitive' theory of psychiatry and using the native categories of psychopathology to organize the case-histories. Only in one section of 40 pages does Devereux employ occidental disease categories, in which he questioned his best informants directly about the occurrence among the Mohave of neuroses and psychoses prevalent in Western society, which they had not spontaneously mentioned; in this way the negative evidence—for example, the apparent absence of anything corresponding to obsessive-compulsive states—has clearly greater validity than the mere absence of records could ever produce. The supernatural component in Mohave ethnopsychiatry would probably render the guiding principles unacceptable to people of an atheist culture, though the grouping of material might usefully cause some reconsideration of our habitual categories. In particular, the Mohave extension of the concept of suicide—a topic which takes up nearly half the book—might well illumine our own preconceptions on the subject. Devereux develops the relationship between Mohave ideas and the obscure construct of the 'death instinct'; although some of his most telling comments are relegated to footnotes (a device to which he is somewhat over-addicted) his treatment of the topic is both sensitive and sensible.

The Mohave are a small group of Indians (a little over a thousand in the 1910 census) living on reservations on the banks of the Colorado river. They have some alluvial agriculture but are, or were, dependent for about half their diet on food-gathering and originally had a diet very low in animal protein. They lived in adobe houses gathered in small settlements; but their loyalties and sense of identity were not localized, but embraced the whole tribe. They are arranged in patrilineal exogamic *gentes* with a totemic name but no significant totemic observances; all the women of a *gens* have the same name and are considered as forbidden 'incestuous' sexual

partners to males of that *gens*. The men were noted for their great courage in tribal warfare, and their prowess as long-distance runners. Their material culture was poor, their basket-work and pottery being notably less accomplished than that of their neighbours; owing to their custom of destroying all the possessions of a dead person at his funeral, there was no accumulation of property or of symbols of wealth. Cultivable land and domestic animals, notably horses, were privately owned.¹

Even for their area, the Mohave are remarkable for the very low development of ritual or of symbolic art—religious song and narrative being the major exceptions; and for the extraordinarily high attention they pay to dreams. Professor Kroeber divided his account of them into two sections entitled 'concrete life' and 'dream life'; for the Mohave believe that all knowledge and special gifts—from healing skills to luck in gambling—are derived from dreams; dreams give information and shape the future; they are the basis of diagnosis and often the most significant symptoms of psychological distress. Although the manifest content of the most significant dreams is stereotyped, all Mohave pay constant attention to their dreams and are ready to describe and analyze them.

It is through this emphasis on the importance of dreams, on the recognition of the dynamic unconscious, that the Mohave have developed an ethnopsychiatry which is worthy of such detailed treatment. Mohave psychiatry, Devereux summarizes, is characterized by:

(i) an ability to tolerate, and therefore to register, observed clinical facts;

(ii) a readiness to empathize with the psychotic and therefore to impute a (psychological) meaning to his behaviour;

(iii) a formulation of this meaning in essentially supernaturalistic terms, in accordance with the basic axioms of the Mohave culture pattern; . . .

(v) a lack of an explicit *general* theory of psychopathology . . .

Devereux groups the psychological disturbances recognized and treated by the Mohave into three categories: disorders of the instincts, mood disturbances, and disorders caused by external beings. It is the third category which is

¹ The facts in this paragraph are derived from A. L. Kroeber: *Handbook of the Indians of California* (Bureau of American Ethnology Bulletin 78, 1925). A major blemish of *Mohave Ethnopsychiatry and Suicide* is that

Devereux has not provided even the briefest summary of Mohave culture. This makes the book unnecessarily obscure for all readers who have not specialized in the study of the American Indians.

most alien to occidental thought. The Mohave consider that psychological disturbances can arise, as though by contagion, from contact with certain dangerous objects, such as snakes or certain magic substances or charms which may turn against their owner; and, more importantly, by contact with aliens or the ghosts of the dead, who are likened to one another and contrasted with the Mohave, because they exhibit the strongly disapproved-of characteristics of covetousness, greed, and stinginess. The Mohave have defined what are usually considered anal traits as pathological for a full-blood Mohave—theft was practically unknown among them, the sense of ownership was very low, and the funeral customs prevented any accumulation of property; and so, if any Mohave did manifest anal traits, this must be the result of natural or supernatural contagion. Formerly, half-breed babies were killed at birth, they were so dangerous. But the dead are covetous, both for the property consumed in their funeral pyre and for the companionship of the living they have left behind, which they will only enjoy in the after-life if the deaths are nearly simultaneous. Moreover a healing shaman may also become a killing witch who keeps the souls of his victims in a special place until his own death, so as to have their services then. Possessiveness and retentiveness are defined as pathological, and were apparently very rare; and no cases are recorded of true phobias, or of obsessive-compulsive states. The actual toilet-training is unemphatic and late, in what is typically the phallic phase, just as normal weaning is postponed to the middle of the third year.

Congruent with this value system is the belief that aggression, even socially approved aggression, such as successful war-making or the killing of witches, is fraught with psychological danger; special psychoses are recognized for hunters, scalpers, and witch-killers. Devereux suggests that the arduous role of shaman is chosen as a defence against aggression (the refusal to use shamanistic powers also produces psychosis); but the aggression may return again when the healing shaman secretly becomes a killing witch.

In a society where the expression of overt aggression is so disapproved of and dangerous to the aggressor it is understandable that suicide is relatively common, both in our sense of the term and in the extension which the Mohave have given to the concept. For the Mohave any death to

which willing assent is given is suicide, whatever the means by which the death is achieved. They include within the concept seven types of death, besides self-killing, from the foetus which refuses to be born alive because it knows it is destined to become a shaman, or the suckling who dies of anger because his mother has become pregnant again (the Mohave completely scotomize envy, and will not admit that even a year-old Mohave should have such an ignoble feeling) through the foolhardy brave who decides not to live long to the witch who incites people to kill him so that he can rejoin and enjoy his victims. True suicide (traditionally by datura poisoning, drowning, or stuffing one's mouth with earth; more recently by gun or knife) follows the withdrawal of expected social support, constant nagging, or as a device to make the survivors sorry. Demonstrative suicide attempts occur at cremations, which are the culmination of the four days of overt mourning—all that is permitted; but these are never, and would seem not to be expected to be, successful.

In contrast to the constraints on aggression, the only major constraint on sexual activity is that imposed by the 'incest' taboos; and these can be circumvented in certain cases by a symbolic 'social suicide', in which a man sacrifices a horse and 'dies' as a member of his *gens*. Heterosexual activity begins well before puberty, and the Mohave have become, in Devereux's terms, 'sex specialists'. Homosexual transvestism is institutionalized; one of Devereux's earliest papers was a most detailed account of two transvestites;² in this book he repeats a long life-history of a female transvestite with (perhaps on account of the book's sponsorship) several sections in dog-latin.

The disturbances of the sexual instinct which the Mohave recognize are, firstly, a form of nymphomania, and secondly exclusive love and jealousy. Like the Lepchas of Sikkim,³ the Mohave have made no allowance in their social arrangements for 'falling passionately in love'; and in both societies, when this does occur, it is socially disruptive and pathognomic. In neither society can a man expect the exclusive possession of his spouse, and it is improper to resent this; but whereas Lepcha marriages are relatively stable, extra-marital intercourse being fugitive and private, Mohave marriages are little more than the legitimization of paternity, and the couples are constantly changing partners. By

² (1937) 'Institutionalized Homosexuality of the Mohave Indians.' *Human Biology*, 9.

³ Gorer (1938). *Himalayan Village*.

our categories nearly all Mohave come from broken homes, and this may help to account for the apparent diffuseness of adult affection and identification, and the high value given to such autistic processes as dreaming. Devereux maintains that there is no genuine (chronic) schizophrenia among the Mohave, though there are certain transitory reactive confusional episodes; and he suggests that suicide is fairly often a substitute for—and possibly also an escape from—schizophrenia.

Mohave Ethnopsychiatry and Suicide is so rich in novel data—there are 140 case histories, ranging from a few lines to several pages of verbatim interviews—and in original re-working of psycho-analytical theory in the light of these data, that no review, however detailed, can do more than indicate the depth and range of the material (even so, it has been necessary to omit any discussion of the very stimulating appendix on the function of alcohol). Anyone who is interested in the developing sciences of social anthropology and psycho-analysis would be well

advised to give the considerable time and effort needed to read this book. The book is very long—well over 350,000 words—and although Devereux writes with great clarity, intermittent wit, and a pretty use of classical parallels, he has made very few concessions to the non-specialized reader. A constant effort of concentration, a willingness to accept such visual unpleasantnesses as the use of colons rather than diacritical marks, to indicate long vowels in native names and terms—his principal informant is written each time 'Hivsu: Tupo: ma'—and the ability to reconstitute a culture from subordinate clauses, or the curiosity to search out other sources, are all necessary for its full appreciation. The rewards, however, are commensurate with the effort demanded. The book should, and I think ultimately will, have an influence on all future work on social anthropology and psycho-analytic theory. There are few books of which this can be said.

Geoffrey Gorer

1962 AWARDS

The Chicago Institute's FRANZ ALEXANDER PRIZE has been awarded to Dr George Engel of the University of Rochester (New York) for his paper "Anxiety and Depression-Withdrawal: The Primary Affects of Unpleasure" (*Int. J. Psycho-Anal.*, 43, p. 89).

(The Alexander Prize is awarded biennially to a graduate of the Chicago Institute for a paper in the field of psycho-analysis.)

The PRIX MAURICE BOUVET has been awarded to Dr Jean J. Kestenberg of Paris for his paper "A propos de la relation éroto-maniaque" (*Rev. franç. psychanal.*, 26, p. 533).

(The Maurice Bouvet Prize was founded in memory of Maurice Bouvet, former President of the Société Psychanalytique de Paris, and is awarded annually for work published in the French language in the field of psycho-analysis.)

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Part 3

TRANSFERENCE PSYCHOSIS IN THE PSYCHOTHERAPY OF CHRONIC SCHIZOPHRENIA¹

By

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After some five years of my work at Chestnut Lodge, developments in the therapy of various of my patients brought home to me the realization that even the most deep and chronic symptoms of schizophrenia are to be looked upon not simply as the tragic human debris left behind by the awesome glacial holocaust which this illness surely is, but that these very symptoms can be found to have—or, perhaps more accurately, in the course of therapy can come to reveal—an aspect which is both rich in meaning and alive, one now sees, with unquenched and unquenchable energy. That is, these very symptoms now emerge to the therapist's view as being by no means inert debris but as, rather, the manifestations of an intensely alive, though unconscious, effort on the part of the patient to recapture, to maintain, and to become free from, modes of relatedness which held sway between himself and other persons in his childhood and which he is now fostering unconsciously in current life in, most importantly, his relationship with his therapist. When the therapist sees and feels this aspect of the therapeutic situation, not only does much which has been bewildering, in his previous months or years of work with the patient, become coherently meaningful; but he senses, even more hearteningly, how great are the patient's potential capacities for growth, capacities which are, it is now evident, far from dead, but, rather, congealed in the perpetuation of these unconscious transference-patterns of relatedness.

This realization came to me most memorably

in two treatment-situations in particular, in my work with a middle-aged hebephrenic man in whom severe apathy was for years a prominent symptom, and a hebephrenic woman of about 30 who manifested, likewise for years in our work together, a degree of confusion which I often found overwhelming and deeply discouraging. I did not find it strange that a man who had been hospitalized constantly, whether on a back ward of a veterans' hospital or on a locked ward at Chestnut Lodge, for more than 10 years, should show a great deal of apathy; nor did it seem remarkable that a woman who had been hospitalized for a similar length of time, and whose records showed that she had been subjected, over the years prior to her admission to the Lodge, to approximately 140 insulin coma treatments and an indeterminate number of electroshock treatments, should be severely and persistently confused. More often than not, when I contemplated, and tried persistently to help, each of these two persons, I found solid reason to feel appalled and helpless in the face of the havoc which chronic schizophrenia, and the diverse efforts to treat chronic schizophrenia, had wrought upon these two human beings.

It therefore came as a tremendous change of view for me to hear the man, who was lying silently on his bed as usual, say one day, with a chuckle, 'If my grandmother was still alive I'd be a *real* lounge-lizard', and to find the evidence accumulating, during subsequent months and years, that his ostensible apathy was that of a person who had felt it necessary to bank the fires

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of his own ambitions and devote himself to staying by a grandmother, and much more importantly, before that, a psychotically depressed father, whose needs—needs to be protected from the daily cares of the world by the patient's more or less constant reassuring presence—took priority over the patient's own life as a boy and as a young man.

Now, ironically, I, who had formerly looked with dismay upon this hopeless vegetable of a patient, found myself in the position, as his transference towards me became more richly and openly elaborated, of a 'papa' to whom he reacted, with persistence and conviction, as being a mere shell of a person, a person with a long-burnt-out mind, a relic given to unpredictable moods of deep depression punctuated by explosive rages. All these qualities had marked his own illness in the preceding years, as a fuller case description would clearly show; and I do not doubt that major ingredients of his illness were originally derived from the introjection of similar qualities in his father. As his transference to me became increasingly coherent and powerful, his own personality-functioning became proportionately liberated from illness; but I must say that there were times, during the ensuing months and years, when the transference role which he not so much pinned onto me as more or less instilled into me, made me feel somewhat less than my usual robust self.

In the instance of the woman patient, it gradually became clear to me that her so deep and persistent confusion consisted basically in an unconscious and ambivalent effort, manifested with especial coherence and clarity in the relationship with me as a father in the transference, (a) to get me to do her thinking for her, as her father had been accustomed to doing throughout her childhood and adolescence until her hospitalization at the age of 19; (b) to prove me incapable of doing this—a motive which could be called, and certainly often felt to me as, a castratively hostile motive, but one which, as I shall subsequently state more fully, is at heart in the service of the patient's determination to be, and function as, an individual in her own right; and (c) to require me to acknowledge openly the extent of my own confusion, confusion such as had indeed been present in the father during her upbringing, and against which he erected as a defence a borderline-psychotic degree of subjective omniscience.

Despite these two therapeutic experiences, and others nearly as memorable to me, when some

years later a fellow seminar-member at Chestnut Lodge raised the simple question, 'What part does transference have in this work?', I shared in the general floundering which we all, despite our analytic training and our considerable experience in the modified psycho-analytic treatment of schizophrenic patients, felt in trying to answer this question.

To be sure, we have long ago outgrown the position, in this regard, of Freud (1911a, 1914) and Abraham (1908), who held that the schizophrenic patient has regressed to an autoerotic level of development and is incapable, therefore, of forming a transference. Furthermore, the concept of transference psychosis, while not yet the subject of a voluminous literature, is not a new one. We have, for example, some cogent statements by Rosenfeld (1952a) to serve as a reliable avenue of entry into this subject:

... If we avoid attempts to produce a positive transference by direct reassurance or expressions of love, and simply interpret the positive and negative transference, the psychotic manifestations attach themselves to the transference, and, in the same way as a transference neurosis develops in the neurotic, so, in the analysis of psychotics, there develops what may be called a 'transference psychosis'. The success of the analysis depends on our understanding of the psychotic manifestations in the transference situation.

... It has been found that the psychotic manifestations attach themselves to the transference in both acute and chronic conditions, so that what one may call a 'transference-psychosis' develops. The analyst's main task in both acute and chronic schizophrenias is the recognition of the relevant transference phenomena and its communication to the patient ...

Some of these chronic schizophrenic conditions seem often quite inaccessible until the relevant facts of the transference-psychosis are understood and interpreted ... (Rosenfeld, 1954).

But, for a variety of reasons, it is not easy to discover this transference psychosis—or, as Little (1958) terms it, delusional transference—dimension in the patient's schizophrenic symptomatology.

To analyst and analytic student alike, the term 'transference psychosis' usually connotes a dramatic but dreaded development in which an analysand who at the beginning of the

analysis was overtly sane but who had in actuality a borderline ego-structure, becomes overtly psychotic in the course of the evolving transference-relationship. We generally blame the analyst for such a development and prefer not to think any more about such matters, because of our own personal fear that we, like the poor misbegotten analysand, might become, or did narrowly avoid becoming, psychotic in our own analysis. By contrast, in working with the chronically schizophrenic patient, we are confronted with a person who has already become, long ago, openly psychotic, and whose transference to us is so hard to identify partly for the very reason that his whole daily life consists in incoherent psychotic transference-reactions, willy-nilly, to everyone about him, including the analyst in the treatment-session. Little's comment (1960) that the delusional state 'remains unconscious until it is uncovered in the analysis' holds true only in the former instance, in the borderline-schizophrenic patient; there, it is the fact that the transference is delusional which is the relatively covert, hard-to-discern aspect of the situation; in chronic schizophrenia, by contrast, nearly everything is delusional, and the difficult task is to foster the emergence of a coherent transference-meaning in the delusional symptomatology. In other words, the difficult thing in the work with the chronically schizophrenic patient is to discover the 'transference-reality' in his delusional experience.

The difficulty of discerning the transference-aspects of one's relationship with the patient can be traced to his having regressed to a state of ego-functioning which is marked by severe impairment in his capacity either to differentiate among, or to integrate, his experiences. He is so incompletely differentiated in his ego-functioning that he tends to feel not that the therapist reminds him of, or is like, his mother or father (or whomever, from his early life) but rather his functioning towards the therapist is couched in the unscrutinized assumption that the therapist is the mother or father. When, for example, I tried to bring to the attention of a paranoid schizophrenic woman how much alike she seemed to find the persons in her childhood on the one hand, and the persons about her here in the hospital, including myself, on the other hand, she dismissed this with an impatient retort, 'That's what I've been trying to tell you! What difference does it make?' For years subsequently in our work together, all the figures in her experience were composite figures, without

any clear subjective distinction between past and present experience. Figures from the hospital scene peopled her memories of her past, and figures from what I knew to be her past were experienced, by her, as blended with the persons she saw about her in current life.

Comparably, in the instance of another paranoid schizophrenic woman, it required several years of therapy before this patient became able to remember, and give me any detailed account of, her mother, who had died shortly after the patient's admission to Chestnut Lodge, and whom I never met. She reacted to me, in the transference, in the spirit of so convinced and persistent an assumption that *I personified* one or another aspect of that mother, that it was extraordinarily difficult for me, also, to achieve a sufficient degree of psychological distance from the relatedness in order to visualize what the relationship between herself and her mother must have been, and to see the role being played, in her view of me—in her various and intense feeling-reactions to me—by a transference-magnification and distortion of various qualities which, in truth, reside in me. One of my notes, concerning a treatment-session which occurred after two and a half years of intensive therapy, includes the following comments:

In today's hour the realization occurred to me that Susan feels hampered in moving out of the Lodge, away from me, by transference feelings from the relationship with her mother, feelings which kept her, for so many years until the advent of her overt psychosis, from leaving her mother. She brought out much material during this hour which made it plain—without her saying so explicitly—that it had never occurred to her that she might have any choice about whether to stay on at home and take care of her mother and the home, or leave and form her own life elsewhere. It was so plain that she had felt she of course must stay and take care of her mother, and that it would be unworthy, despicable, unthinkable, even to entertain thoughts of doing anything else. I've noticed for some several months that she often reacts to me as though I were an isolated person, in the backwash of life, someone she seems to feel called upon to minister to in many ways; so often, for example, she has prefaced her remarks by saying, gently, 'Dr Searles—?', as though assuming that I am preoccupied. But never

till today did this transference element occur to me at all. Today it came to me with utter conviction. I have long ago felt that she was reacting to me as a condemnatory mother, a rejecting mother, a fond mother; but never before have I realized this particular element, in which I am reacted to as an elderly, lonely, desperately needful mother.

She and I have not reached any consensus at all as to the fact that these feelings are partially on a transference basis, and I am not trying to push that upon her attention.

On the other hand, as I have mentioned, one of the great reasons for our underestimating the role of transference is that it may require a very long time for the transference to become not only sufficiently differentiated but also sufficiently integrated, sufficiently coherent, to be identifiable. This situation is entirely comparable with, though much more marked in degree than, that obtaining in the evolution of the relationship between neurotic patient and analyst, an evolution in which, as Glover (1955) has described with great clarity, the patient evidences, in the early phases of the analysis, *fleeting* indications of positive and negative transference in the course of development of the coherent and persistent *transference-neurosis*:

... from the time we have ascertained that this transference situation [i.e., the transference-neurosis proper] is developing, everything that takes place during the analytic session, every thought, action, gesture, every reference to external thought and action, every inhibition of thought or action, relates to the transference-situation . . .

A hebephrenic woman evidenced, for about three years following her admission to Chestnut Lodge, an extreme degree of ego-fragmentation and a bewildering lack of transference-identifiability in her chaotic behaviour both in her daily life on the ward and in her functioning during the therapeutic sessions. But gradually she developed such a degree of ego-integration that not only did our sessions come to possess, now, a quality of coherency of meaning throughout each session and a comparatively ready traceability of her reactions to childhood experiences, but also the ward staff, previously utterly unsure of where they stood with her, became able to see that she had reconstituted her childhood-family on the ward, with this person being rather consistently misidentified by the patient as

being her older sister, that person being perceived as the mother, another as the long-time family nursemaid, and so on.

Another reason for the therapist's slowness in feeling the role of transference in the psychotherapy is that when, after perhaps many months of a 'relationship building' phase of treatment during which he has found much reason to become confident that, at long last and after many painful and discouraging rejections, he personally has come to matter to this previously so-inaccessible patient, it comes as a particularly hurtful rejection to see to what a great extent the patient has been reacting to him not as a person in his own right but rather as the embodiment of some figure in the transference. One may discover that even one's physical housing, let alone one's more subtle personal feelings, is not really perceived as such by the patient. One paranoid woman, for example, used to shriek at me the anguished accusation that I had cut off my hands and grafted there the hands of her long-dead grandmother, in order that the sight of her grandmother's hands, extending from my cuffs, would tear her heart with grief and guilt, about this grandmother. For a number of years she was convinced, similarly, that the head she saw on my shoulders was not really mine, but was that of one or another person from her past. The therapist under the impact of transference of this power feels very alone indeed, with little or no confirmation of *himself* coming by way of any feedback from the patient.

To my mind, the most fundamental reason of all for our finding it difficult to discern, and to keep in view the evolving course of, the transference in the therapy of these patients is that the transference is expressive of a very primitive ego-organization, comparable with that which holds sway in the infant who is living in a world of part-objects, before he has built up an experience of himself, and of his mother and other persons round about him, as beings who are alive and whole and human. Transference as one sees it in the neurotic patient implies three whole persons—the patient, the therapist, and a person who figured in the patient's early life. The schizophrenic patient has never solidly achieved a level of ego-differentiation and ego-integration which will allow him to experience, three whole persons, or even two whole persons, or, as yet, one whole person. The question of whether he will ever achieve such a level of ego-maturation will depend, more than anything

else—in so far as the therapist's contribution is concerned—upon the latter's capacity to perform three tasks. First, the therapist must become able to function as a *part* of the patient and to permit the patient to be genuinely, at a deep level of psychological functioning, a part of himself. Secondly, he must be able to foster the patient's individuation (and, to a not insignificant degree, his own re-individuation) out of this level of relatedness, a level which is conceptualized variously by several workers in this field—by Kleinian analysts (Klein *et al.*, 1955) as being a transference-phase dominated by projective identification on the part of the patient; by Little (1960) as being a phase in which the patient has a heretofore-unconscious delusion of total undifferentiatedness with the analyst; and by most writers, including myself, as being a phase of symbiotic relatedness between patient and doctor. The therapist's third task is to discern, and make interpretations concerning, the patient's now-differentiated and now-integrated whole-object, that is to say neurotic, kind of transference-manifestations. With the achievement of the patient's individuation as a whole person and his capacity to perceive the therapist as a whole person, what was formerly in him a transference-psychosis is now a transference-neurosis.

It may be questioned whether the chronically schizophrenic person's ego-organization is, in its entirety, at every moment, and in relation to whatever person, as incompletely differentiated as my foregoing comments indicate; one recalls here the valuable papers by Katan (1954) and Bion (1957) concerning the non-psychotic part of the personality in schizophrenia. But in any event I consider it valid to conceive of the patient's *transference to the therapist* as being in the nature, basically, of a relatedness to the therapist as a mother-figure from whom the patient has never become, as yet, deeply differentiated. Furthermore, I believe that this 'sickest'—least differentiated—aspect of the patient's ego-functioning becomes called into play in *any* relationship which develops anything like the intensity that the therapeutic relationship develops.

Concerning the symbiotic phase in the therapeutic relatedness, which I cannot attempt here to discuss comprehensively, I should like at the moment merely to note how difficult it is to discern and conceptualize the transference in those situations where, however frequent they may be, it is always astonishing to discover to

what an extent the patient is relating *to himself*—or, more accurately, to a part of himself—as an object. A hebephrenic woman, for example, often sounded, when alone in her room, through the closed door as though a castigating, domineering mother and a defiant child were locked in a verbal struggle in there. Another hebephrenic woman, trying to formulate an upsurge of jealousy at a time when she had just acquired some long-sought-for liberties to go unescorted into the nearby village, said, 'I guess I'm jealous of myself'; there was a peculiarly ego-splitting kind of pain in her voice as she said this, and with repercussions in me as I heard it, which is hard to convey in words. A hebephrenic man, who generally spent his sessions with me in silence and who was intensely threatened and furious whenever I started to speak, interrupted me at one such juncture with the furious command, 'Just sit there until ya catch yourself!', and later in the therapy was able to experience the same phenomenon in an unprojected form: when I inquired what he was experiencing, he replied, 'I'm playin' possum, tryin' to catch myself.' Still later on in our work, when I heard him murmuring some words which by then had become stereotyped, such as, 'Take your time . . . You don't say . . . Behave yourself . . .', and I asked, 'Who are you saying that to, Bill?', he replied, 'I'm just sittin' here echoin' myself.'

Similarly, Freud in a paper which included some data from his work with a schizophrenic patient, made the comment that ' . . . Analysis shows that he is playing out his castration complex upon his skin . . . ' (Freud, 1915). Szasz (1957) has reported many instances of patients' having formed transferences to various parts of their own bodies. Furthermore, the whole of Klein's (Klein *et al.*, 1955) formulations concerning the importance of internal objects in mental functioning are relevant here.

To the extent that the patient is absorbed in reacting to a part of himself, whether a part of his body or one of his internal psychic objects, what then is the nature of the transference to the therapist who is in his presence? It is, I think, most useful to think of the transference, here, as being to the therapist as a *matrix* out of which the patient's ego-differentiation and ego-integration gradually develops, by successive identifications with this originally so undifferentiated and unintegrated, but at some level of relatedness truly external, transference 'object'.

In an earlier communication (1960, p. 352) I reported a hebephrenic woman's saying ap-

prehensively, in clear reference to me, 'There's a weird doctor around here that doesn't make sense to me. 'He's metal—he's [looking uneasily at the walls of the room] everything.' I asked, 'Wooden?', thinking of the wood on the walls of her room in which we were sitting. She nodded agreement and added, 'He's everywhere'. Later in the therapy, as I have detailed elsewhere (1961c), both participants' anxiety, and retaliatory hostility, in the symbiotic phase of the transference have become sufficiently resolved for each to experience the other as comparably omnipresent, comparably pervading one's whole existence; no longer, however, is this felt as a malignant, threatening and constricting presence, but rather as a benign and nurturing one.

The British analysts who embrace Klein's theoretical concepts have written more than anyone else about transference psychosis and its therapeutic management. Their approach is based upon her concept of projective identification. The most relevant of her views are to be found in her paper of 1946, 'Notes on Some Schizoid Mechanisms':

I have often expressed my view that object relations exist from the beginning of life, the first object being the mother's breast which is split into a good (gratifying) and bad (frustrating) breast; this splitting results in a division between love and hate. I have further suggested that the relation to the first object implies its introjection and projection, and thus from the beginning object relations are moulded by an interaction between introjection and projection, between internal and external objects and situations . . .

. . . With the introjection of the complete object in about the second quarter of the first year marked steps in integration are made . . . The loved and hated aspects of the mother are no longer felt to be so widely separated, and the result is an increased fear of loss, a strong feeling of guilt and states akin to mourning, because the aggressive impulses are felt to be directed against the loved object. The depressive position [in contrast to the earlier, above-described paranoid position] has come to the fore . . .

. . . in the first few months of life anxiety is predominantly experienced as fear of persecution and . . . this contributes to certain mechanisms and defences which characterize the paranoid and schizoid positions. Out-

standing among these defences is the mechanism of splitting internal and external objects, emotions and the ego. These mechanisms and defences are part of normal development and at the same time form the basis for later schizophrenic illness. I described the processes underlying identification by projection [i.e., projective identification] as a combination of splitting off parts of the self and projecting them on to another person . . .

Rosenfeld, a follower of Klein who has contributed several highly illuminating papers concerning schizophrenia, writes (1952a),

. . . I have observed that whenever the acute schizophrenic patient approaches an object in love or hate he seems to become confused with this object. This confusion seems to be due not only to phantasies of oral incorporation leading to *introjective* identification, but at the same time to impulses and phantasies in the patient of entering inside the object with the whole or parts of his self, leading to '*projective* identification'. This situation may be regarded as the most primitive object relationship, starting from birth . . . While projective identification is based primarily on an object relationship, it can also be used as a mechanism of defence: for example, to split off and project good and bad parts of the ego into external objects, which then become identified with the projected parts of the self. The chronic schizophrenic patient makes ample use of this type of projective identification as a defence . . .

In another paper, he presents detailed clinical data which serve to document the implicit point, among others, that whereas the schizophrenic patient may appear to have regressed to such an objectless auto-erotic level of development as was postulated by Freud (1911a, 1914) and Abraham (1908), in actuality the patient is involved in object-relatedness with the analyst, object-relatedness of the primitive introjective- and projective-identification kind. For example, Rosenfeld concludes his description of the data from one of the sessions as follows:

. . . The whole material of the session suggested that in the withdrawn state he was introjecting me and my penis, and at the same time was projecting himself into me. So here again I suggest that it is sometimes possible to detect the object-relation in an apparently auto-erotic state.

... only at a later stage of treatment was it possible to distinguish between the mechanisms of introjection of objects and projective identification, which so frequently go on simultaneously (1952b).

We find, among the writings of the Kleinian analysts, a number of interesting examples of *delusional-transference interpretations*, in all of which the keynote is the concept of projective (or introjective) identification. For instance, Rosenfeld writes at one juncture (1952a),

The patient himself gave the clue to the transference situation, and showed that he had projected his damaged self containing the destroyed world, not only into all the other patients, but into me, and had changed me in this way. But instead of becoming relieved by this projection he became more anxious, because he was afraid of what I was then putting back into him, whereupon his introjective processes became severely disturbed. One would therefore expect a severe deterioration in his condition, and in fact his clinical state during the next ten days became very precarious. He began to get more and more suspicious about food, and finally refused to eat and drink anything . . . everything he took inside seemed to him bad, damaged, and poisonous (like faeces), so there was no point in eating anything. We know that projection leads again to re-introjection, so that he also felt as if he had inside himself all the destroyed and bad objects which he had projected into the outer world: and he indicated by coughing, retching, and movements of his mouth and fingers that he was preoccupied with this problem . . . I told him that he was not only afraid of getting something bad inside him, but that he was also afraid of taking good things, the good orange juice and good interpretations, inside since he was afraid that these would make him feel guilty again. When I said this, a kind of shock went right through his body; he gave a groan of understanding, and his facial expression changed. By the end of the hour he had emptied the glass of orange juice, the first food or drink he had taken for two days . . .

In another paper (1954) Rosenfeld writes, concerning his work with an acutely schizophrenic girl who was intermittently overwhelmed with confusion and unable to speak,

... She then looked at me for quite a time

and said: 'Why do you imitate me?' I interpreted that she had put herself into me and that she felt that I was her and had to talk and think for her. I explained to her that this was the reason why she felt so shut in when she came to my house and why she had to escape from me. She was now looking much more comfortable and trusting, and said: 'You are the world's best person'. I interpreted that because she felt I was so good she wanted to be inside me and have my goodness.

... Following the interpretations that the patient felt she was inside me, she was able to extricate herself out of me which lessened her confusion. She then became more aware of me as an external object and was able to talk . . .

Bion (1956) defines projective identification as

... a splitting off by the patient of a part of his personality and a projection of it into the object where it becomes installed, sometimes as a persecutor, leaving the psyche from which it has been split off correspondingly impoverished.

The following brief example of his use of verbal interpretations comes from his work with a schizoid man:

... As the silence continued I became aware of a fear that the patient was meditating a physical attack upon me, though I could see no outward change in his posture. As the tension grew I felt increasingly sure that this was so. Then, and only then, I said to him, 'You have been pushing into my insides your fear that you will murder me'. There was no change in the patient's position but I noticed that he clenched his fists till the skin over the knuckles became white. The silence was unbroken. At the same time I felt that the tension in the room, presumably in the relationship between him and me, had decreased. I said to him, 'When I spoke to you, you took your fear that you would murder me back into yourself; you are now feeling afraid you will make a murderous attack upon me.' I followed the same method throughout the session, waiting for impressions to pile up until I felt I was in a position to make my interpretation. It will be noted that my interpretation depends on the use of Melanie Klein's theory of projective identification, first to illuminate my counter-trans-

ference, and then to frame the interpretation which I give the patient.

It seems to me that the above instances of verbal transference-interpretations can be looked upon as one form of intervention, at times effective, which constitutes an appeal-for-collaboration to the non-psychotic area of the patient's personality, an area of which, as noted previously, both Katan (1954) and Bion (1957) have written. But, particularly among long-hospitalized chronically schizophrenic persons, we see many a patient who is too ill to be able to register verbal statements; and even in the foregoing examples from Rosenfeld's and Bion's experiences, it is impossible to know to what extent the patient is helped by an illuminatingly accurate verbal content in the therapist's words, or to what extent that which is effective springs, rather, from the feelings of confidence, firmness, and understanding which accompany these words spoken by a therapist who feels that he has a reliable theoretical basis for formulating the clinical phenomena in which he finds himself.

In trying to conceptualize such ego-states in the patient, and such states of relatedness between patient and doctor, I find of additional value the concepts presented by Little in her papers, 'On Delusional Transference (Transference Psychosis)' (1958) and 'On Basic Unity' (1960):

... a neurotic can recognize the analyst as a real person, who for the time being symbolizes, or 'stands-in' for his parents . . .

Where the transference is delusional there is no such 'stand-in' or 'as-if' quality about it. To such a patient the analyst *is*, in an absolute way, . . . both the idealized parents and their opposites, or rather, the parents deified and diabolized, and also himself (the patient) deified and diabolized . . .

The transference delusion hides a state in the patient which he both needs and fears to reach. In it subject and object, all feeling, thought, and movement are experienced as the same thing. That is to say there is only a *state of being* or of experiencing, and no sense of there being a *person*; e.g., there is only an anger, fear, love, movement, etc., but no person feeling anger, fear or love, or moving. And since all these things are one and the same, there is no separateness or distinction between them. It is a state of undifferentiatedness, both

as regards psyche and soma, experienced as chaos.

To reach this state is a terrifying thing, as it means losing all sense of being a person, and all sense of identity. The patient who reaches it becomes for the moment only a pain, rage, mess, scream, etc., and is wholly dependent on the analyst for there being anywhere a person who feels or acts. There is in fact, identification with the analyst of primary kind, but the patient cannot be aware of it.

This state has to be reached so that the unreality of these identities can be recognized, but the reaching of it is felt as utter annihilation—hence the need to maintain the delusion in the transference . . .

[Concerning] the state of undifferentiatedness which the delusion hides . . . The terms 'primary identification' and 'primary narcissism' to my mind do not fit it, nor does 'paranoid-schizoid position'. I would rather describe it as a state of primordial undifferentiatedness, or of *basic unity*, in which a primitive identification might be said to be included. What I want to convey is that the undifferentiatedness is absolute, in both degree and extent. Nothing exists apart from anything else, and the process of differentiation has to start from scratch (1958).

Little not only takes issue with various of the Kleinian theoretical concepts, but stresses the importance of physical movement and contact in helping to resolve the delusional transference:

Rosemary has never sorted herself out from her sister Joyce, who is 2 years older. All childhood happenings, ideas or feelings are told of the entity 'we'; ('We did this, We hated that'). She and Joyce are indivisible; she 'never feels a person', but is often 'two people', and sometimes 'half a person'. At the beginning of a session she frequently doesn't 'know how to begin' . . .

... Rosemary was functioning separately on at least two different levels, and I am understanding the separateness as being due to a failure of fusion, rather than to the action of a splitting mechanism . . .

Throughout her analysis she has continued to be paralysed with terror, and unable to find any starting-point other than something happening in me. . . . Her silence and immobility can remain total for weeks on end, and only when I show signs of life in some explicit way (for anything merely implicit is

useless) can she begin to tell me what has been going on . . .

In the light of this idea of absolute identity between patient and analyst I think we have to reconsider our ideas of such mental mechanisms as projection, introjection, condensation, displacement, and all that Freud included in the term 'dream work'.

. . . we can see here how what we have considered to be condensation becomes instead a regression to the primordial undifferentiated state. Similarly, . . . what appeared to be an projective identification turned out to be an assertion of absolute identity with me (1960).

I have worked with patients so deeply differentiated that only after several years of intensive therapy did they become able to distinguish between an 'outside' and an 'inside'. Until such a development has occurred, one may find Little's formulations helpful in approaching the patient; subsequently, the formulations of Klein and her followers, which imply both a far higher degree of psychic structure (differentiation) and a far greater reliance upon verbal interpretations, are in my experience oftentimes pertinent. It is not a matter, I believe, of our having to choose between irreconcilable theoretical concepts, but rather to determine in which phase of the patient's ego-development each is more useful for us.

Four Varieties of Transference Psychosis

Transference psychosis—or, in Little's (1958) phrase, delusional transference—may be defined as any type of transference which distorts or prevents a relatedness between patient and therapist as two separate, alive, human and sane beings. In what follows here, I shall present a variety of examples of such transference, examples which I have encountered in my clinical work and each of which I consider useful as being typical of clinical situations with one patient after another. The theoretical framework which I shall use as a vehicle for presenting clusters of these typical situations is one of which I feel much less than sure; but, beyond providing some presentational coherence, it represents the clearest theoretical integration of these seemingly dissimilar clinical phenomena which I have thus far been able to formulate. I should explain also, by way of prefacing these descriptions, that any one patient will be apt to show, over the course of treatment and perhaps in any one therapeutic

session, all four of the different varieties of transference psychosis which I shall describe.

(i)

Transference-situations in which the therapist feels unrelated to the patient. In these situations, the therapist may find the patient reacting to him as being an inanimate object, an animal, a corpse, an idea, or something else not essentially human and alive. I have included many examples of such situations in my monograph on the role of the nonhuman environment in normal development and in schizophrenia (1960), and here I shall merely enumerate a few sample-situations which are not described there. My present understanding of such situations is that they are genetically traceable to the part-object world of infancy and very early childhood—the era during which the child has not yet achieved a differentiation between animate and inanimate, between human and nonhuman, in the surrounding world and in himself, and has not yet built up, through accumulated part-object relatednesses, an image of himself and of his mother as whole and separate objects. I have termed the phase of therapy in which such transference-relatedness—or 'unrelatedness'—predominates the 'out-of-contact phase' (1961c), and have indicated that the early-life era which is etiologically pertinent is that from which, as Mahler (1952) describes it, autistic childhood psychosis stems, as contrasted with the developmentally later symbiotic childhood psychosis; the former type found, by Mahler, in the child who had never become firmly involved in the mother-infant symbiosis typical of later infancy and early childhood in healthy maturation, and the latter type found by her in the child who had become involved in a symbiotic relationship with the mother, but had never outgrown this mode of relatedness.

The patient's misidentification of the therapist is a typical clinical situation in point here, in addition to the varieties mentioned in my monograph. One paranoid schizophrenic man, reared as a devout Catholic, would attend Mass at the local church each Sunday, and then when I arrived for the Monday hour he would regularly misidentify me as a priest; this he would do with a degree of certainty which I found quite uncomfortable, despite my soon coming to realize that, in all probability, he was thus repressing, through this delusional misperception of me, feelings of disloyalty to his church which were

aroused by his receiving treatment—however unwillingly—from a psycho-analyst, a situation to which he thought his church adamantly opposed, and one to which his deceased mother had been in any case unswervingly hostile.

The transference-position of one who is continually and at times bizarrely misidentified can be a very stressful position for the therapist to endure. One hebephrenic woman misidentified me continually, for months on end, as a succession of dozens of different persons from her past, such that I found the lack of confirmation of myself, as I know myself, to be almost intolerable. I have already described the paranoid woman who used to shriek with anguish and condemnation, while gazing over at my hands, that I had cut off the hands of her grandmother and fastened them onto myself in order to turn a knife in her heart; and who upon innumerable occasions reacted to my head as being, not my own, but the decapitated and grafted-on head of one or another person she had known. On one occasion she said to a nurse, 'Even your voice can be changed by wiring to sound like the voice of a person that I know'. She once declared to me, with chilling conviction, her certainty that I was a machine sent to kill her; and, at another time, that I was a woman who had killed my husband and was about to kill her, likewise.

Similarly, the delusional transference may consist in the patient's feeling misidentified by the other person. A paranoid woman, when responded to fondly and at length by a nurse who had known her for a long time, confided, as the nurse reported it, that 'she felt when I was talking to her that I was actually talking to a third person outside her window. This 'third person' she said was 'angels' . . . A spinster, when in one therapeutic session I tried to promote our mutual exploring of sexual conflicts which were emerging from repression in her, protested, 'Why do you talk to me like that, Dr Searles?'; sometimes this was said with a warm, pleasurable laugh, but at other times in such a way as to make clear that she felt, as she said, 'uncomfortable'. At one such point she seemed to go completely out of contact and, when I asked her what she was experiencing, she replied, 'You make me uncomfortable when you talk like that, Dr Searles.' I asked her how she felt I talked and she replied, 'As if I were an old married woman.' I then asked her if she felt I was not talking to *her* on such occasions, and she agreed. I then suggested that naturally enough

she felt removed from the situation, and she agreed with this also. There were a number of similar occasions when she behaved as though not psychologically present in the situation, evidently feeling totally misidentified by me, when my remarks were too widely at variance from her own self-concept.

In much the same vein are the instances of a patient's misidentification of himself, such that, in the instance of one paranoid woman, she assumed for many months that she was her own mother, and her children were not the two actual children I knew to be hers but were, rather, her three adult siblings. This had an utterly literal reality for her, quite beyond any figurative implications apparent enough to an observer; so, for weeks on end, I felt quite cut off from the person I knew her to be. Another paranoid woman would, one might say, literally become her mother at times of increased anxiety; another way of saying it is that a pathogenic introject derived from her mother would take over and dominate her behaviour and her sense of identity, such that one could only wait at such times for her paranoid tirades to run down until that which one knew as her real self became accessible and able to hear one's comments. The hebephrenic woman I have already mentioned, who in each hour misidentified me as being dozens of different persons from her past, from the movies, and so on, misidentified herself just as continually. On rare occasions she would ask, pathetically, if I had seen Louise (her own name) lately; it had evidently been a long time since she had seen herself, even fleetingly. Even this rare use of her own name was an indication that she felt more nearly in touch with herself than she usually did.

Also to be mentioned in this same category of phenomena are instances where the patient reacts to the therapist, in the transference, as being but one among his myriad hallucinations, or as possessing even less reality than do the hallucinatory figures. A childless hebephrenic woman, when I would come into her room, would experience me as '1500 men' who were interfering with her relationship with her daughter. It appeared that she was misidentifying herself as being her mother, and was experiencing herself-as-a-child in the form of the hallucinatory daughter outside herself, a hallucination towards which she was far more absorbed in attempted relatedness than she was with the hallucinatory men into which her perception of me devolved. In another instance later on she

explained, exasperatedly, while ripping her clothes—a symptom of hers which, for many months, was maddeningly and discouragingly difficult to control—that she was trying to ‘get through’ me as, she made clear, the personification of her father, in order to ‘reach my mother’ experienced by her, apparently, as an hallucinatory presence in the room apart from either of us. In the instance of a hebephrenic man, for months I felt reacted to by him as being no more than part of the woodwork, a mute and non-participative onlooker to his lively interactions with a group of hallucinatory figures in the room—a group which, as the months wore on, assumed more coherence and identifiability as his childhood family. Later on there was a phase during which I felt that he now registered me in his awareness as comparable with, and invested with something like as much feeling as, the hallucinatory figures with which he had for so long been immersed, and now I found myself feeling competitive with, and often jealous of, his hallucinations. Still later I reached a point where I felt sure that I mattered to him far more than did his hallucinations, so that whenever he began to hallucinate I could readily see this as subsidiary to—that is, as an unconscious defence-mechanism related to some event in—his relatedness with me as a real person.

Another form of psychotic transference which causes the therapist to feel strikingly unrelated to the patient is that in which the patient is reacting to *him* as being psychotic. Hill (1955) has noted that

... Sometimes it is quite striking that the patient comes to believe that the doctor is thoroughly psychotic, quite in the fashion in which he himself has been psychotic ...

In my experience, this is an integral part of the transference-evolution seen over the course of therapy with chronically schizophrenic patients. Each such patient has had at least one parent who evidenced borderline schizophrenic ego-functioning, *if not openly psychotic behaviour, during the patient's childhood, and it will then* be in the nature of his unfolding transference to his therapist that he will come to regard the months on end, as being emotionally inaccessible (out of contact), delusional, and given, perhaps, to unpredictable and potentially murderous outbursts. Hill describes it that it is thus, in the schizophrenic patient's view, that at the end of his treatment

... He is good, and the badness is left with the doctor. Even the illness is left with the doctor ... (1955).

In earlier papers I have given detailed examples of this form of delusional transference, and have emphasized the need for treatment to be pursued far beyond this phase, until the craziness has been well resolved, rather than simply left in this projected form upon the therapist (1959a, 1961c). But here I wish simply to note how important it is that the therapist be able to endure the explicit emergence of such a transference on the part of the patient, towards him. Bion makes some interesting comments concerning—by contrast—the etiological significance of the patient's projection of his own *sanity*, which help to highlight this point concerning the necessary transference-evolution:

I spoke of Melanie Klein's picture of the paranoid-schizoid position and the important part played in it by the infant's phantasies of sadistic attacks on the breast. Identical attacks are directed against the apparatus of perception from the beginning of life. This part of his personality is cut up, split into minute fragments, and then, using the projective identification, expelled from the personality. Having thus rid himself of the apparatus of conscious awareness of internal and external reality, the patient achieves a state which is felt to be neither alive nor dead ...

Projective identification of conscious awareness and the associated [i.e., consequent] inchoation of verbal thought is the central factor in the differentiation [in any one schizophrenic person] of the psychotic from the non-psychotic personality ... (1956).

... patients will use the mechanism of projective identification to rid themselves of their ‘sanity’. If the analyst appears by his conduct to condone the feasibility of this, the way is open to massive regression ... I am absolutely in agreement with Maurits Katan [1954] in his views on the importance of the *non-psychotic part* of the personality in schizophrenia (1955).

The therapist who cannot endure the patient's reacting to him as insane—who cannot stand the projection of the insane part of the personality upon him, but who unwittingly fosters and as it were insists upon the patient's projection of his own sanity upon him—cannot succeed in helping

the patient to distinguish between the sane and insane ingredients of the patient's own personality, and in helping him to resolve the insanity.

These considerations have shed, for me, additional light upon the psychodynamics at work in the borderline or schizoid patient who is described by Helene Deutsch (1942) and Annie Reich (1953) as relating to others in an 'as if' fashion—as if he were experiencing a deep emotional involvement, when he is really incapable of relating except on the basis of a primitive identification of an imitative sort, traceable to his superficial identification with a narcissistic mother. I find that the nascently genuine emotionality is kept under repression in such a patient, originally out of a need to shield his mother from such real and spontaneous emotion. Comparably, I find it typical of borderline patients in general that not only their emotionality but their ego-perceptions in general are held subjectively in great doubt, and hence their sense of reality is impaired, for the reason that one's parent—or, in the therapy-session, the therapist—must be spared from the reality of those perceptual data which the patient *tends* to see or hear or otherwise sense full well and accurately; but in the transference he has reason to doubt that the therapist-mother or -father can stand exposure to it, by reason of the near-psychotic narcissistic brittleness of ego-functioning which he attributes to the therapist, traceable to his experience with such a narcissistic mother as Deutsch and Reich describe.

Thus in the treatment sessions the patient tends to feel 'like a bull in a china shop', as various patients have expressed it, severely constricted in thought and feeling with, perhaps, their psychic productions taking shape, in their own view, only fuzzily like indistinct images on a TV screen. One of my patients regularly prefaces, or immediately afterwards tries to undo, her most penetrating observations, concerning either myself or her parents or whom-ever, with the apologetic statement, 'I know I'm crazy . . .'. Another borderline woman patient at the Lodge, who shows a remarkably accurate perceptiveness as to what is going on in me, as indicated by either verbal or non-verbal communicational nuances, regularly gives me a way out of facing the reality of these by qualifying her comments with 'I sort of got the impression just then that . . .' or 'It seemed to me as if . . .', or 'I don't know, but I just had the thought that . . .'. I now understand a little better why

a schizoid patient whom I treated years ago once went to the extent of putting it that, 'A sort of a half an idea just crept into my unconscious: . . .'. On the basis of a lifetime of experience with an extremely brittle mother, he was, as I now realize in retrospect, putting it thus tentatively on the assumption that I could not stand more direct exposure to the thought-and-feeling which he was conveying. These matters do not involve, I wish most strongly to emphasize, merely forms of communication on the patient's part; they extend into, and to a high degree permeate, his subjective experience, his perceptual functioning in general, so that he may feel quite out of touch indeed with thoughts and feelings which, in the transference, he unconsciously senses to be too threatening to the parent-therapist.

Brodey's (1959, 1961) papers, reporting his observations and theoretical formulations concerning the family therapy of schizophrenia, have been very helpful to my discovering the transference-meanings which I have just mentioned. Brodey describes how greatly the schizophrenic patient's awareness of reality is constricted by reason of a need to be attentive to the mother's inner workings, and he says that, for example,

. . . One patient while psychotic seemed alive, vibrant, and was most discerning in her relationship with the mother; but she was psychotic and her behaviour unpredictable to the extreme. As she moved from this position back to what would be called by the mother 'reasonableness', she returned to being a puppet dancing with every movement of her mother's hand with lifeless accuracy . . . (1961c).

(ii)

The second category of *instances of transference psychosis* is that comprising those situations in which a clear-cut relatedness has been established between patient and therapist, and the therapist therefore no longer feels unrelated to the patient; but the relatedness is a deeply ambivalent one. My theoretical concept of such situations is that the transference-evolution has unearthed that era of the patient's ego-development in which the mother-infant symbiosis had come to possess too high a degree of ambivalence for him to have been able to follow the healthy sequence from identification with mother to the subsequent establishment of

successful individuation; the ambivalence had been too intense for him to develop an integrated ego, and his ego-development had been turned, instead, into a defensive autism which left him vulnerable to the later development of schizophrenia. Thus, in the transference-evolution to the therapist, he deeply hungers for, and must have if he is to become born as a real person, a symbiotic relatedness with the mother-therapist which is comparatively free from ambivalence—a phase analogous to the preambivalently symbiotic phase of the healthy mother-infant relationship. But he fears this, too, as being equivalent to the annihilation of himself, or the mother-therapist, or both.

Such theoretical concepts have been arrived at largely empirically, 'after the fact' as it were, emergent from the accomplishment of difficult clinical work.

I worked with a luxuriantly and most persistently delusional paranoid woman, for example, for four years before discovering, in the course of the next few months, two of the transference-determinants (various additional ones became clear to me in later years of the therapy) which had been forming 'the fountain-heads of all her so bewildering delusions. I consider it significant that these revelations of the nature of the transference came to light only after her previously tenacious fear and hostility had given way to a considerable degree of positive feeling in the transference.

One of these approximately concomitant revelations came to light in an hour in which she said, with a striking amount of fondness, in reference to the female therapist who had worked with her at a previous hospital, 'If I had that doctor to talk to every day, I could even tolerate life here at Chestnut Lodge.' She went on to describe this therapist in terms strikingly similar to those she had applied, over the years, to 'my so-called mother'. What emerged in essence, during this hour and over the subsequent few months, was a revelation of the intense loyalty she had felt, all along, towards the earlier therapist, such that I now understood in retrospect why, over these four difficult years, in her loud defiance of and manifold resistance to therapy, she would often loudly proclaim that she was 'upholding the standards of the medical profession'. She had been upholding what she believed, with an incredible degree of confusion and distortion, to be the standards of Doctor X, the former therapist, who was so little differentiated, in her perception, from her own mother.

Actually, both her mother and Doctor X were remembered by her as being multiple figures, of varying sexual identities. I felt little inclination to be critical of the former therapist, for every critical implication which the patient's words bore towards that therapist, she had long made, and for a long time would yet make, towards me also, during periods when I was, for her, such a mother-figure—or, more accurately, such mother-figures—in the transference.

To return to my point here, I wish simply to emphasize what a revelation it was for me to see how greatly, for her, any positive feeling towards me, any achieved bit of collaboration in the therapy with me, conflicted with her sense of loyalty to the former therapist, and, by the same token, to what a great degree her discouragingly persistent delusions comprised, *en bloc*, a formidably massive effort to fend me off so that she could preserve her loyalty to the former therapist, in turn so transparent a screen for her own mother who, as her father told me and as I found abundantly documented in the events of the transference-relationship, 'loved to dominate' the patient as a child and demanded the patient's loyalty to her views, no matter how conflictual, divergent, self-destructive, nonsensical, and simply crazy those views in fact were.

The other of these concomitant revelations can perhaps be best conveyed by quoting my notes concerning an hour approximately two months following the hour alluded to above:

The work with her has gone extremely well, and very collaboratively, again ever since about 12 March [three weeks ago]. In today's hour she was dressed in a very cute dance-costume, looking both very cute in a small-girl way and very seductive in a mature-woman way, with many flirtatious raisings of her skirt as she dissertated about theology, philosophy, and the complex workings of the world in general. Very early in the hour she accused me, in an unstinging way, of having 'lustful', 'erotic' desires. It actually was, much of the time, a quite anxious hour for me, with my feeling that she and I were interacting at two quite separate levels: (1) debating (she was doing the great bulk of it); and (2) a non-verbal sexual level, what with her sexy posturings and skirt-liftings. My discomfort consciously related to my feeling that the sexy business on her part was dissociated; so I felt, as it were, alone in having to deal with it. But late in the hour I chided her lightly,

telling her, 'You've been giving me a difficult time, prancing around in that outfit looking cute as can be, and accusing me of having lustful, erotic desires.' She laughed in a pleased way; so I guess her own erotic feelings can't be too heavily repressed at the moment.

But there was an additional very significant development in this hour: it became more apparent to me than ever before—I've seen it before but never realized the influential strength of this particular dynamism—that she not only loves to debate actively (which I've long known) but that she almost certainly greatly misses, unconsciously, the probably hours-long debates she used to have with her mother—at least I'm pretty sure it was her mother [confirmed by abundant data subsequently in the therapy]. She herself always refers to it as 'they' who used to say so-and-so; she was quoting to me, during this hour, much of the debates they used to have—quoting what she used to say and then telling me what 'they' used to say. The point of all this is that today I realized, better than before, that all this delusional thinking, *en bloc*, provides a way of relating which she greatly enjoys, a way of relating which I'm very inclined to think characterized a relatedness with her mother which she greatly misses, unconsciously. It became quite clear to me today that her behaviour is not oriented towards any satisfactory resolution, content-wise, of the arguments, the debates. As I told her, I feel that she would say that a tree is a dog, if necessary, to start a good argument; I said this in a friendly way, feeling friendly. I feel sure that she does not realize the dynamics of this as yet.

In the final section of this paper I shall discuss the matter of *interpretations* of transference-psychoanalysis. At the moment, I wish to note that one of my great difficulties in the work with this woman had to do with my susceptibility to being drawn into arguing with her delusional utterances. On innumerable occasions I could no longer sit silent while the most basic tenets of my concept of reality were being assaulted, not merely by the content of her words but by the tremendous forcefulness of her personality; on these occasions, the preservation of my sanity demanded that I speak. On other occasions, I would argue in an effort to rescue her from a degree of delusional confusion which was, on

such occasions, indubitably genuine and indescribable here; to say that a tree is a dog would be only the tiniest measure of her confusion at such times. On still other occasions, when her anxiety was much less and there was little of any urgent helplessness or threatening domineeringness on her part, she would simply make it irresistible fun to argue with her.

No matter in what spirit the arguments ensued, they always served, for her, as a way of simultaneously relating me, emotionally and psychologically, to herself and yet keeping me safely separate from herself, outside herself. These arguments were so difficult to deal with successfully in the therapy because they were the expression of her ambivalently-symbiotic relationship with her mother. She needed so much for us to be psychologically one person—an experience which had not been successful in her early relationship with her mother—and yet, for very good reasons in her history, she felt that this would amount to the annihilation of both of us. The subsequent months and years of the therapy included a clear-cut preambivalently—that is, relatively non-ambivalently—symbiotic phase, the culmination of which she experienced as a literally becoming born; but at this phase which I am describing, her arguing—and my reciprocal arguing—represented a mutual deferring of that phase. She held it off partly by the defence-mechanism of arguing; others of my patients have shown other types of defences used for the same purpose.

It is significant that this woman came to describe, eloquently and feelingly, how intensely exasperating she used to find it when her older brother—who for a long time in her treatment she insisted was 'my mother'—'got into my mind' in the course of arguments between them, rather than, as I would put it, maintaining his position in outer reality. She clearly conveyed how utterly helpless she would feel on such occasions, when she would experience him as a physical presence 'in my mind', where, so her words and gestures conveyed, she could not get her hands on him, and therefore could not reach him.

A hebephrenic woman came to express her ambivalently-symbiotic relatedness, or one might say her need for, and avoidance of, symbiosis, in a way more primitive than the arguing of which the paranoid woman I have just described was capable. She came to maintain for years, on the one hand, a demeanour of stony and silent antagonism toward me, seeming

genuinely not to see me much of the time; yet on the other hand this demeanour would be interlarded with moments when she would make urgent pleas for oneness with me. Her history indicated that her relationship with each of her parents had been, until she became overtly psychotic in her early twenties, ambivalently symbiotic in nature. A note made concerning an hour in the sixth year of our work, at a time when I had become comparatively free from enmeshment in an ambivalently symbiotic relationship with her—at a time when I had come to feel, with predominant relief but with some guilt and concern, that I had ‘fallen out of love with her’—suggests something of her striving to regain the symbiosis with me:

The work with Ellen continues to show, most prominently, her making clear her ambivalent effort to achieve, and to avoid, a symbiotic relatedness with me as a representative of her father. It seems to me of late that, because of my sense of separateness from her which is so much greater than that of a few years ago, her emphasis is mainly on the efforts to achieve [i.e., to regain] such a relationship.

Thus, for example, in yesterday's hour she indicated her doubt that she could survive if I stepped out of the room for a moment to get a cup of coffee, which I did. I cannot overemphasize how poignantly she expresses this kind of anxiety, such that in retrospect I am not surprised that I had such tremendous difficulty in going ahead years ago and functioning freely in the face of her anxiety and pleas in this direction [i.e., pleas for symbiosis].

This woman had once confided to me, ‘My father lives when he gives to me’, and the years of our therapeutic collaboration provided abundant evidence that one of the major aspects of her delusional transference to me was as a father whose own life demanded the perpetuation of a symbiotic relationship wherein he ‘gave’ incessantly to her, ‘solicitously’ lived her life for her, and so on.

(iii)

The third category of instances of transference psychosis are those in which the patient's psychosis represents, in the transference, an effort to complement the therapist's personality, or to help the therapist-parent to become established as a separate and whole person. These clinical situations, which appear quite diverse, all

represent the patient's living out, in the transference, of the difficulty he has had since early childhood with a parent who has not proved strong enough, on his or her own, to accept the resolution of a symbiotic relationship which should have predominated only in the patient's infancy and early childhood. Because the parent is able to relate *only* symbiotically to the child, the child is given to feel that the resolution of the symbiotic mode of relatedness will mean the death of the parent, and his own potentially individual self is thus experienced by the patient as an inherently murderous self. The anxiety defended against by the schizophrenic symptomatology may be looked upon as springing from the simultaneous conviction that (a) the desperately-needed symbiotic experience (no matter how formulated, or incapable of formulation, in the patient's mind) is tantamount to death as an individual, the erasure of individuality; and (b) the goal of fully-achieved individuation is seen as equivalent to the murder of the parent.

These are far from being simply delusional notions on the patient's part, without any basis in reality. I have been struck, for instance, with the highly significant circumstances in which fatal or near-fatal cardiovascular accidents, quite beyond the much more frequent upsurges in anxiety of sometimes psychotic proportions, have occurred among parents of recovering schizophrenic patients. Several such incidents have occurred in the families of patients with whom I have been working; but this statistically insignificant sampling grows to sobering proportions when one sees it supported by similar incidents which have occurred in the course of my 14 years of work at Chestnut Lodge, in the collective experiences of, in cumulative total, perhaps 50 therapists who have worked with hundreds of patients here, over the years. Such patients have had much solid historical reason to sense their own growth-impulses as being inescapably murderous in nature, and therefore as being necessary to contain at all costs.

Comparatively early in my experience here, in my work with a catatonic young woman, I came to see that one of the determinants of various kinds of helplessness on her part consisted in an unconscious effort to promote her father's becoming a man; her persistent hope evidently was that he would find himself as man in the course of rescuing her from the situation in which she was floundering. This determinant became clearly revealed in the unfolding of her transference to me, and evident to both of us;

the working through of her disappointment in her father, in this connexion, was one of the solid achievements in her therapy. Since then, I have found the same unconscious 'motive' in various other schizophrenic patients, in one form or another.

A 45-year-old hebephrenic woman, for example, given for years to maddeningly fragmented and semi-audible speech, and equally maddening physical contrariness and unmanageability, came eventually to make clear that this represented, in the context of the transference-relationship to me as a father, her effort to promote my making myself more firmly delineated, as it were—more explicit, more decisive, more firm. I had met her father, who died of a coronary occlusion a few months after her entry into intensive psycho-therapy at the Lodge, and I had found him to be a remarkably inscrutable man. She had evidently found him so, too, and she made clear, in the transference, that she had found him to be, as well, a maddeningly indecisive person, who had as it were driven her out of her mind with his tantalizing indecisiveness and his crushingly disappointing failure to see things through. As she once put it, he 'always gave up two-thirds of the way up the mountain'; their symbiotic relatedness had consisted in her regarding him, overtly, as an adored pal, with whom she hiked, played tennis and golf, went horseback riding and sailing, and shared her experiences (by detailed subsequent reports) with boy friends whom she always compared unfavourably with him. They also played musical instruments together.

In the transference relationship, I early found that she was trying not simply to seduce me sexually, but was trying to get me to become a man by having intercourse with her. Once, for example, she wiggled her bare buttocks at me suggestively and, when I failed to make the apparently-desired response, she quickly began showing increasing exasperation and said to herself, with great annoyance, 'Charlie [her father's nickname, which she generally used in referring to him and often used in referring to me] never did know how to play the bass clef!'

But comparable realizations on my part, concerning other manifestations of this same motive of father-building in the transference, were arrived at only with the greatest of difficulty. It was only after several years that I discovered that one of the major determinants of her deeply schizophrenic mode of communication, which as I say was maddeningly fragmented and semi-

audible, consisted in an effort on her part, an evidently genuinely unconscious effort, to foster my declaring myself, delineating myself, through my responsive efforts at filling in and clarifying which this mode of speech tended powerfully to evoke from me. Such schizophrenic speech tends to function in a way analogous to a Rorschach test, inviting the therapist's own projective self-revelations. Similarly, it was only after years of the most maddeningly indecisive and unmanageable behaviour on her part, whether during attempted walks in the hospital grounds with me or with various other personnel members, or when asked to perform any physical act, however ostensibly simple, that I realized that *her* extreme indecisiveness represented, in part, her effort to promote the other person's (in the therapeutic sessions, my) becoming decisive through his or her eventually becoming completely out of patience and cutting through all indecisiveness in the situation by a furiously impatient and unequivocal command.

Other more verbal and better integrated patients have come to make clear that their delusional utterances represent, in part, an effort to get the therapist to make clear where he stands—to determine how crazy or how sane he is, to find out what is his view of the people and events and things with which the patient is concerned. It has often come to me as not only a useful but also as an amusing realization to discover that my supposedly delusional, confused patient is now involved in trying the delusions upon me for size, or is otherwise involved in doing a kind of mental status examination of me. Recently a long-hebephrenic and genuinely disoriented woman murmured haltingly to me, 'What's the date?', and I started patiently to tell this poor benighted soul the date, when I suddenly realized that, from her view, it was I whose psyche was in question, and that she was trying cautiously to discern whether *I* knew the date. Space does not allow for an attempt to document conclusively that this is what her seeming disorientation, earlier in our work quite genuine indeed, had come to mean; all I can ask is that one does not forget that this is what one's patient may be doing with one. When this dimension of the transference-relationship comes into view, it comes to one's attention that an astonishing number of bits of behaviour on the patient's part are interpretable in this light, as being evidence of a persistent, unending watchfulness for, and when opportunity affords itself, a brief and covert investigation of, data

which indicate that the parent-therapist is sane or insane. It makes sense that this must have indeed been an important dimension of the patient's childhood—an important concern to him as a child—when we consider how afflicted has been the ego-functioning of at least one, and often both, of his two parents.

Similarly, I have found, and reported elsewhere, that a schizophrenic patient's expression of genuinely confused and delusional utterances may represent an unconscious effort to foster the creative imagination of the other person—the therapist, for example, the therapist perceived in the transference as being constricted, unimaginative, uncreative. I have seen this motive become clear and conscious in various of my patients. But in the instance of a hebephrenic woman it did not become clear to me until she physically loosened my too-tight shirt collar, which brought home to me the realization, in retrospect, of how many were the ways in which she had been trying, so to speak, to loosen my collar—trying to promote my living a freer and less obsessively constricted life. I might add, parenthetically to any considerations about transference, that she has helped me greatly on this score. The schizophrenic patient's need to cure the therapist may dovetail in a useful way with the therapist's determination to become free from characterological obsessiveness.

Quite analogous is the schizophrenic patient's effort—a largely unconscious effort until it emerges from repression during the course of therapy—to relieve, by his crazy utterances and behaviour, depression in the other person. Depression is an important dimension in any schizophrenic patient; only after much therapy is he strong enough to feel it as his own, and until such time as he can, he has to project it upon the therapist (and other persons), and thus feels impelled to relieve it by schizophrenic symptoms which the other person may find infuriating, puzzling, or perhaps delightfully diverting, but in any case a way out of depression. Another way of viewing this phenomenon is to see that depression was prominent in the patient's parent(s) in his childhood, and in some instances oppressively permeated the whole family's life together; in the transference this becomes carried over to the therapist, who is often viewed as being on the verge of suicide. The suicidal feelings which are present, whether actively or latently, in every person (except those individuals who are too deeply schizophrenic for such feelings to be accessible to them) become

mobilized in the therapist, making for one of the genuinely great difficulties in doing successful therapy with these patients. Seen in the over-all context of the hospital, some of those patients who are most severely 'stuck' in their ego-development, year after year, are the hospital's well-known colourful characters, living legends, whose crazy antics, past and present, have served the function of relieving depression in the collective patients-and-personnel about them in the hospital community.

I personally have never felt more powerfully impelled towards suicide than I was during some months when a previously hebephrenic woman was working through her feelings towards me as being the personification, in the transference, of her long-depressed father. She had made clear to me that, at one time or another, each of her three other family members had been withdrawn, weeping, and 'yelling around about suicide'; but this had evidently been most severe in the father. He, a person much older than his wife, had fondly (though also enviously) told his daughter that she had 'all the vermilionishness of life', as she had once put it during the hebephrenic, highly neologistic earlier period of our work together. One of the ways in which she complemented him was by functioning as his own lost youth. She was both young, as he no longer was, and the girl he had never been and could never be. It was in part out of poignant experiences with her that I wrote a paper entitled, 'Schizophrenia and the Inevitability of Death' (1961b). The working-through of this aspect of her transference-symbiosis with me took years to accomplish.

For years she habitually went about looking like a little girl dressed up in vivid but miscellaneous and out-of-style clothing, often reminiscent of the 'flapper era' chronicled in, for example, the cartoons by John Held, Jr., in the *College Humor* magazine of the 1920s and '30s. I was often annoyed by her attire, and embarrassed by it as an advertisement of the therapeutic capabilities of the man, namely me, who had been her therapist for an embarrassingly long series of years; she often went to unstinting and at times highly creative effort to constitute such an advertisement of herself. All this had, of course, a transference root derived from her experience in 'advertising', by her schizophrenic symptoms, her parents who were painfully conscious of matters of social position. Her older brother once confided to me his concern lest the patient, who had shown no little

murderousness during her life both at home and in the sanatorium, might be released from the hospital prematurely and might murder somebody. This was a reasonable concern; but I was startled when the brother went on to explain that he would not wish such a thing to happen, for the reason that it would 'embarrass the family'. I was both determined that my vulnerability to personal embarrassment should not lead me into trying to dictate what the patient should wear, and recurrently touched, moreover, by the little-girl delight which she evidently found in her own attire, so that I could not bear to hurt her feelings by going beyond comparatively gentle suggestions that, yes, the attire is pretty but the orange doesn't go very well with the purple; or, yes, the hat is pretty but the dress looks a bit out of style, say thirty years or so.

Then one day, a few weeks after we had found that we had each chanced to see and like the movie, 'The Sweet Bird of Youth', she came into the hour wearing, among other miscellaneous adornments (such as a black, scalloped slip and dramatic, blue-lensed eyeglasses) a taffeta skirt covered with giant splashes of colour, a skirt such as would be unlikely to be found anywhere but in a child's dream. She asked me eagerly, gesturing towards her skirt, 'Don't you think this looks like the sweet bird of youth?' It was this development which brought home to me the realization that, whereas all along I had felt that *I* was being tender to *her* in not bluntly opposing her wearing of such attire, she evidently was wearing it out of, in part, a tender concern for *me*—a concern to provide me, as a father in the transference, with Youth. I replied something like this, 'Alice, as a little boy I used to wear an aviator's helmet that buttoned down under the chin, like this—. As I say, I liked it, and I might for example come in here wearing it some day. I might want you to admire it—and possibly you would; but I think you might have *some* feeling that my aviator's helmet, buttoned down under my chin, would be a *bit* out of place'. She took this well, and I believe it was not so much the expressing of a gentle correction as, rather, the conveying to her that I could accept the loss of my own youth which helped her eventually to get over this particular symptom.

(iv)

The fourth variety of transference psychosis is manifested at a phase in therapy in which *the deeply and chronically confused patient, who in*

childhood had been accustomed to a parent's doing his thinking for him, is ambivalently (a) trying to perpetuate a symbiotic relationship wherein the therapist to a high degree does the patient's thinking for him, and (b) expressing, by what the therapist feels to be sadistic and castrative nullifying or undoing of the therapist's efforts to be helpful, a determination to be a separately-thinking, and otherwise separately-functioning, individual. During my years of work at Chestnut Lodge, I have successively seen the basically transference-nature of schizophrenic confusion; the intense though largely unconscious sadism which is being expressed in this confusion, by the subjectively helpless patient whom the dedicated therapist is trying to rescue from the confusion; and, lastly, the striving towards individuation which is at the core of those aspects of the patient's functioning which have seemed, heretofore, primarily intended sadistically to torture, and in one fashion or another to castrate, the therapist.

One chronically confused hebephrenic woman, who for years in her therapy evidenced much idiotic behaviour and on repeated psychological examinations was found to have a subnormal I.Q., had been trained by her father throughout her upbringing how to think. As a natural extension of this, he had coached her as to what to say in various social situations, and had taught her to memorize various witticisms which amused him and which she found essentially meaningless. She became schizophrenic during her teens, at a point where it had become evident that this idolized-father symbiotic partner of hers had, in actuality, feet of clay. She then oriented her life, for several years, around a delusional omnipotent figure, a kind of composite of powerful persons, real and imagined, from past and present life, and addressed hundreds of pleas for rescue, from the hospital, to, for example,

My Father, Zirey Edward Butcher
Head of the Marshall Airfields
All over the Place
or
My Old Man . . .
Head the Boss of Radio City
Head of General Motors
The World's Fair
Head of Standard Oil
Head of the Conferences . . .
or, in at least one instance,
. . . Head of Those Things.

A tiny sample of the vast extent to which her functional imbecility came from emotional, transference sources became evident in an hour when she was describing—against, as usual, massive confusion—her struggle to hold a job as a secretary, years ago, during an interim between two of her long successions of hospitalization. She managed to bring out her conviction that the customary salutation in a business letter, 'Dear Sir', is *indicative of both promiscuity* (as regards the 'Dear') and of *boot-licking* (as regards the 'Sir'). I had long ago found much evidence to indicate that her possessive father had forbidden her participation in either 'promiscuity' or 'bootlicking' to such an extent that it had been impossible for her to develop more than the rudiments of any friendships with other young people. It had long ago become clear that she had been given to feel that she must have no other gods before him—before him, who, she had quite literally believed up until her schizophrenic break, was omniscient.

In the transference relationship with me she would recount, with hebephrenic laughter, meaningless fragments of jokes that 'were going around New York' years before—always meaning, so I came to know, idiosyncratic jokes which she had heard from, specifically, her father. Always my failure to laugh in response to these unfunny 'jokes' was taken by her as confirmation that I was, like the mother upon whom she and her father had habitually heaped scorn, devoid of a sense of humour and therefore incapable of functioning upon the high plane occupied by that symbiotic twosome. For fully three years I was, in the transference, predominantly this scorned mother.

But then she began reacting to me as being, more and more clearly, the know-it-all father, and her confusion gradually took form as representing on the one hand a desperate effort to get me to clarify the awesome confusion with which she was genuinely afflicted, and on the other hand a mocking, sadistic, eroding kind of nullification of my efforts to be helpful to her in this very regard.

More than anything, I was patient; with seemingly endless patience and solicitude I tried to help this pitifully confused girl, and only later on did I realize that she had construed my overt calmness, gentleness, and patience as being evidence of the same maddeningly aloof, know-it-all quality she had come to hate—as therapy had by now established—in her father. It was characteristic of her to deny the fact of her own

confusion; she had, no doubt, too little ego-strength to be able to face this awesomely helpless aspect of herself.

A turning-point came near the end of an hour filled with the usual inundatingly confused verbalizations from her. I had recurrently commented, 'That was puzzling, wasn't it?', or 'It's confusing to you, isn't it?'. Each time she had flatly denied that she was confused—had denied it in a way which I found progressively exasperating, since I felt very much confused most of the time myself, and since her tone, as well as her verbal content, was clearly one of confusion and puzzlement.

Finally, near the end of the hour, when for the nth time she had flatly disclaimed being confused, I burst out sarcastically and very exasperatedly, 'Well, if it's clear to you, congratulations, Louise! It sure as hell isn't clear to me; I've been confused by about 80 per cent of what you've been saying this hour. But if it's all clear to you, congratulations! You know, it's one thing to be confused and to know you're confused, and it's another thing to be confused and not even know you're confused. At least if you realize you're confused, that's a beginning!' Previously, I had been concerned to protect her from the realization of how very confusing I had long been finding her desperate efforts to convey her thoughts to me.

Significantly, it was in the very next day's session that she told me, more clearly than ever before, how exasperating it had been to her during her upbringing that her father would never admit that he was wrong about something, would never admit that there was something he didn't know. It was at this point that I realized in retrospect that one determinant of her years-long confusion had been an effort, apparently largely unconscious, on her part to thwart, and prove fallible, me as the know-it-all father in the transference. Subsequently she was much more accepting of my efforts to help her in the resolution of her severe and chronic thought-disorder.

Another hebephrenic woman, who had likewise participated, until the onset of her schizophrenic psychosis, in an overtly idolizing but covertly competitive symbiotic relationship with her father, for several years placed me under extreme pressure—by reason of her manifest helplessness, despair, terror, and often mutely abandoned and unloved demeanour—to get me to do her thinking for her, as her father had evidently done in bygone years. Incessantly I

was kept under pressure to guess aloud at the meanings which were supposedly nascent in her fragmentary, ambiguous, and half-inaudible speech, or in her oftentimes odd non-verbal communications. Despite the fact that she would almost invariably react with an undermining sneer when I did manage, by dint of flights of intuition, to guess correctly, I kept trying with dogged devotion—and, as became increasingly evident, I was trying overmuch to, as she phrased it, 'put words in my mouth'.

It was such infringement on her striving to think for herself, and to become free from the transference-symbiosis, that brought forth her most sadistic responses to me. In an earlier paper (1959a) I have conceptualized such responses as an effort to drive the other person crazy. She eventually came to make this sadistic motive quite explicit, in such statements as—near the end of an hour in which she had made clear, on the one hand, how much she suffered from genuine fragmentation of all her perceptual functions—'I hate doctors! That's why I make things mush!'

This was the same woman who had said, earlier in our work when I was trying, as usual, to rescue her from her despair-filled fragmentation, 'There's a weird doctor around here that doesn't make sense to me. He's metal—he's—everything', while looking uneasily about.

Rosenfeld (1954) states that

In the acute schizophrenic state the patient tends to put his self so completely into objects that there is very little of the self left outside the object. This interferes with most ego-functions, including speaking and understanding words . . .

And Bion (1956) presents some extremely stimulating concepts, to the effect that one of the essential features of schizophrenic personality is a hatred of reality, which is extended to all aspects of the psyche that make for awareness of it, such that his own perceptual ego-functions, as well as his attempted collaborativeness with the analyst, is subjected to hostile splitting-mechanisms.

It seems to me that the concepts of both Rosenfeld and Bion do not take into adequate account a factor inherent in the early family life of the patient, wherein the invasiveness of the symbiotic parent(s) was such as to prevent the child from meeting a genuine reality either outside himself or within himself as an individual. We need to see that it is not reality as such which

the patient hates, but rather the only 'reality' which he has so far known, a symbiosis-derived pseudo-reality, a reality derived, in Brodey's (1959, 1961) terms, from the mother's (or, I would add, the father's) 'inner workings'. It is this 'reality', this facet of the pathogenic symbiosis, which the patient is healthily—though seemingly so sadistically and castratively and destructively—determined to shed, in order to emerge and be born as an individual.

A chronically paranoid woman, whose mother, in the words of an uncle who gave us an admission history, had 'loved to dominate' this child and had given the girl, from her own isolated, eccentric, ambulatory schizophrenic social position, unequivocal but remarkably contradictory edicts as to how to think and behave in various situations, came to reveal, in the course of our several years of work together, various of these psychodynamics with unusual clarity.

Like one of the foregoing hebephrenic women, this patient became able to acknowledge the fact of her own confusion, defended against for years by vociferously uttered delusional certainties, only after I had come to experience, and openly reveal, a deep confusion in myself in reaction to her forcefully and tenaciously-expressed delusions, which I came eventually to feel as seriously eroding all the underpinnings of my sense of identity, all the things about myself of which I had felt most sure: namely, that I am a man, that I am a psychiatrist, that I am engaged in fundamentally decent rather than malevolent work, and so on and so on. She now became able to say, simply and seriously, 'I don't know anything', and to evidence a steadily diminishing resistance to my therapeutic efforts.

I knew that the death of her mother had been one of the circumstances, if not the centrally significant circumstance, attending the onset of her paranoid schizophrenia, several years ago. A time came in our work when, in a spirit of unusually positive transference, although as usual she was delusional and confused, she was struggling unusually hard to try to understand and convey to me what she was experiencing during the course of the session. At one point she explained to me, 'You see, my mother was my mind', and this was said in such a tone as poignantly to convey the implication, 'and when I lost her, I lost my mind.' It was painfully clear during the hour to what an awesome extent she had indeed lost her mind, as measured by the incredible depth of her confusion, quite unreproducible here.

As far as her transference to me during this same session was concerned, I felt that all her productions, taken together, amounted to a vigorous effort to induce me to provide her with guidance, direction. She did make quite explicit her struggle at present to, as she put it, 'build a world', and was clearly trying to persuade me to work with her in figuring this out, or hopefully to show her how to do it. Part of the time she was working with pencil and paper, drawing a diagram of a very tall H, a turtle, an ark, a saucer, and one or two other items. Included in the notes I made subsequent to this session was the comment,

What makes this so terribly difficult is that her competitiveness, her castrativeness, which is so much out of her awareness, is so strong as largely to nullify such efforts as I do make to respond to her indubitably sincere collaborativeness.

But it gradually became very clear to me, and confirmed by her, that the 'getting well' I sought to help her achieve was to her synonymous with getting castrated. This concept she acted out in various ways, in schizophrenic symptomatology which sometimes made one's flesh creep, as when—to mention but one among many diverse incidents—she stripped all the leaves off some luxuriant plants which she had been carefully nurturing in her room. She began revealing these various crazy acts, she was obediently following the directions which she heard coming from 'that woman in my head', who was evidently an introject, no matter how distorted by the patient's own anxiety and hostility, of the crazy mother of her childhood.

In one of the more amusing of our sessions, she suddenly reported to me, 'That woman in my head just said, "Don't have anything to do with that frump out there".' She confirmed my amused assumption that 'that frump' referred to me. At another point in the hour, she protested vigorously, when I had suggested, as had long been my custom, 'Let's see what comes to your mind next', 'You keep asking me what's in my mind—she's in my mind; but she has nothing to do with me!'. She went on to make it evident that by herself felt utterly ignored and unrelated to words, whenever I endeavoured, with those words, to encourage her to express herself. Usually we think of the person's mind as the locus and very core of his self; but she showed me that this was by no means true for her. It was

evident, in retrospect, that when, all along, I had been endeavouring to help her explore and elaborate what was in her mind, she had been reacting as though my effort had been to stamp out finally her upward-struggling autonomy, to castrate finally her individuality, so to speak, by rendering permanent and total the sway which the introjected symbiotic mother already held over her ego-functioning.

Before leaving this discussion of the forms in which transference-psychosis is manifested, it should be noted that just as all these various forms may be shown by any one patient, at one time or another in the course of his psychotherapy, so is it impossible to demarcate clearly between transference-psychosis in general, on the one hand, and transference-neurosis on the other hand.

Freud (1911b) made the comment that

We have long observed that every neurosis has as its result, and probably therefore as its purpose, a forcing of the patient out of real life, an alienating of him from reality . . . Neurotics turn away from reality because they find it unbearable—either the whole or parts of it. The most extreme type of this turning away from reality is shown by certain cases of hallucinatory psychosis which seek to deny the particular event that occasioned the outbreak of their insanity. But in fact every neurotic does the same with some fragment of reality . . .

Bion, in his paper in 1957 concerning the differentiation, in any one schizophrenic patient, between what he calls the psychotic personality and the non-psychotic personality, concludes the presentation of his theoretical formulations with,

. . . Further, I consider that this holds true for the severe neurotic, in whom I believe there is a psychotic personality concealed by neurosis as the neurotic personality is screened by psychosis in the psychotic, that has to be laid bare and dealt with.

And in a paper in 1959, in which I described a phase of symbiotic relatedness in the transference-relationship between the schizophrenic patient and his therapist, as being at the core of the resolution of the schizophrenia, I included the general statement that

. . . My experience indicates, further, that such a [symbiotic] relatedness constitutes a

It was true that, as much as two years before I realized this, he had once replied to one of my questions with the disappointed and disgusted comment, 'There's no friendly intuition here!', in such a way as to make me realize that, if the degree of friendly intuition existed between us that he was hungering for, no words would be necessary. But one reason why I was so slow to make this later discovery is that this hebephrenic man would habitually tell not only me, but various other persons about him when they made overtures, 'I'm a stranger', and so on; hence I missed the personal significance of it in our relationship. This is all another way of pointing up the patient's need for a predominantly silent, basically symbiotic relatedness with the therapist.

I might mention that in a later predominantly wordless 'therapeutic symbiosis' phase of my work with the previously-mentioned paranoid schizophrenic woman, we were sitting in her room during one of the sessions, in a comfortable, fond silence, and she was peacefully knitting. I started to say something, and she interrupted me with, 'What's the matter—aren't you satisfied with what you're getting on your radar?' I started to protest, 'Yes, but—', whereupon she said, in the way a fond mother would firmly but gently admonish a little child, 'Then be quiet.'

I did not then attempt a transference interpretation, nor do I feel, in retrospect, that one was in order. Many times, earlier in our work, she had shown great pressure of speech, and had protested against my comparatively silent participation with the statement that she couldn't stand 'the intimacy of silence'. This I regard as an instance of the so frequent situations, with these very deeply ill patients, when it is essential for the therapist to be able not only to endure, but also to enjoy, a wide variety of transference-positions in relation to the patient, before the patient can become able, acknowledgedly and explicitly, to accept him as a *therapist* to such a degree as to be able to attend to verbalized transference-interpretations from him. To try to do this prematurely, before the therapeutic-symbiosis phase has been allowed to develop and has come towards the end of its usefulness to the patient, is tantamount to the therapist's using the concept of transference as a kind of shield to protect himself from the necessary degree of psychological intimacy with the patient, in a way quite analogous to the patient's own unconscious use of his delusional transference as a kind of

shield to protect himself from experiencing the full reality of the therapist as a person in the present.

There is widespread agreement that it is inherent in therapy that the therapist functions as an auxiliary ego to the patient in the patient's struggle with inner conflicts, until such time as the patient, by identification with the therapist's strength, becomes able to make this greater strength part of his own ego. To the extent that the schizophrenic patient does not possess an observing ego of sufficient strength to permit the therapist usefully to make transference-interpretations, to that degree the therapist must be able to endure—and, eventually, to enjoy—various part-object transference-roles, until such time as the patient, *via* increasing ego-integration, becomes able to see the delusional-transference nature of this view of the therapist. Another way of saying this is that the patient develops ego-strength, in the face of his own id-impulses and pathogenic superego-retaliations, *via* identification with the therapist who can endure, and integrate into his own larger self, the kind of subjectively non-human part-object relatedness which the patient fosters in, and needs from, him.

Several writers have made clear that interpretations of transference psychosis must extend beyond the merely verbal level. Bion (1955), for example, comments:

... for a considerable proportion of analytic time the only evidence on which an interpretation can be based is that which is afforded by the counter-transference.

He evidently uses the term 'counter-transference' to refer to the analyst's feeling-reactions to the patient's transference. He illustrates the role of the analyst's feelings in this regard by a description (quoted earlier here) of a successful transference interpretation derived, initially, only from Bion's own awareness of a fear in himself that the patient was contemplating a murderous attack upon him, without there having been at that moment any discernible outward change in the patient's demeanour.

Little, in one of her papers concerning patients in whom she finds a delusional transference to exist, emphasizes, concerning these patients, 'the supreme importance for them of body happenings', and says, albeit in somewhat tantalizingly vague phraseology,

... the body events may become the interpretations. Verbalization then becomes

the second stage in a two-stage process, both stages being necessary for real insight to be attained, but the second only effective as a result of the first, i.e. of the body happening.

. . . Discharge, and consequent differentiation [out of the delusional basic unity], comes through some body event—a movement, a scream, salivation, etc.—by means of which some kind of bodily contact with the analyst occurs. Through repetitions of such events the patient comes gradually to recognize the difference between his body, his sensations, and his emotions, while those of the analyst are discovered as separate from his. The event has concerned two people, and the patient discovers himself as a person who has moved, screamed, etc., in relation to another person, whose separate existence, experience, movements, and responses can also be recognized. The delusion breaks up, recovery begins, and relationship becomes a possibility.

The importance of these body happenings lies in the fact that in those areas where the delusion is operative the patient is to all intents and purposes literally an infant, his ego a body ego. For him, in these areas, only concrete, actual, and bodily things have meaning and can carry conviction . . . (Little, 1960).

The following comments by Little show how important she considers it to be, to the patient, that he be as it were free to feel at one with the analyst—in line with my own views; but she evidently feels less sure than I do that the analyst inevitably participates in this in reality, and that this mutuality of what I call the therapeutic symbiosis is indeed essential to a successful therapeutic outcome. That is, where I would say that the patient's 'delusion' of basic unity with the analyst needs to become a mutually shared reality between the two participants, she comments, variously, that

[Concerning one particular woman] . . . Her recovery has been based on this delusion of total identity with me, which has had to be gradually broken down, as far as factual reality is concerned, while the psychic reality of it has had to be preserved with the greatest care . . .

. . . the delusion [of unity with the analyst], although accepted as true for the patient, is not shared by the analyst (unless, unfortunately, he has something of a countertransference psychosis).

. . . The underlying principle [of relevant analytic technique] . . . is that of acceptance by the analyst of the truth *for the analysand* of his delusion of absolute identity between them, his entering into it, and demonstrating both its psychic truth and its objective untruth.

. . . If the analyst is sufficiently one with his patient psychically, he experiences him, at times, as himself, or himself, at times, as the patient. But because of his unity with himself he also experiences what he says or does to be himself . . . (Little, 1960).

Boyer has reported upon his use of a modified analytic technique, in his office practice with schizophrenic patients, which apparently conforms more nearly to classical psycho-analysis than does any other reported approach by anyone treating such patients. Even he, while not making mention of any use of physical contact between himself and the patient in the course of his interpretations of delusional transference, does highlight the crucial significance of physical phenomena in these patients:

It is to be remembered that with inadequate differentiation of ego and id, tensions are often fixated to physical phenomena . . . In a previous report (Boyer, 1957) I have recorded a fragment of the history of a schizophrenic whose analysis was given tremendous impetus through repetitious direction of his attention to physical tension and movements . . .

. . . preverbal communications are of signal importance with many, if not all, regressed patients. The analyst's understanding of them and communication of their meanings enables patients not only to break through resistances and to help them to learn about realities, but to restore body-ego deficiencies and to separate self from non-self. In addition, their interpretation helps analysands to progress in ego growth to where they can accurately communicate in words. It is not unusual . . . that the words being *said* may have little importance as messages in themselves, but constitute the contributions of a decathected part of the self, while the meaningful cathexis is invested in the posture and movements of the moment (Boyer, 1961).

In general, while my own approach is far from being as abstemious as Boyer's appears to be, I cannot wholeheartedly accept Little's enthusiastic endorsement of physical contact; I have seen a number of clear-cut instances in which my

declining to provide physical contact has been as helpful, in promoting the resolution of delusional transference, as has been my touching of the patient on other occasions. In a recent paper (Searles, 1963a), concerning the role of neutral therapist-responses in the therapy of the schizophrenic patient, I have emphasized that if one is to help him to become subjectively alive, one must be unafraid of functioning as the transference-representation of the subjectively unalive parts of the patient's self, or as the very early-perceived attributes of the mother, before she had emerged as a whole and alive and human being in the perception of the infant. Prior to such a development the mother, and comparably the therapist in the transference situation, is so very important to the patient—as one chronically paranoid patient phrased it, a Coke machine for the automatic gratification of his needs—that, from his view, the mother or the therapist must not have a separate aliveness. A therapist who is neurotically afraid of physical contact with people, including schizophrenic patients, to that degree complicates the recovery process in the patient; but so does the therapist who recurrently needs to reassure himself of his own living humanness, his own capacity for feeling, by a dramatically 'curative' employment of physical contact with the patient. In the latter instance, it is only ostensibly the trembling and frightened patient who is being helped by the therapist's reassuring touch; covertly the patient is thereby reassuring the therapist of the latter's own capacity for life and lovingness.

Milner (1952), in her beautiful account of her therapy of an 11-year-old boy who had found outer reality mechanized and soulless by reason of its unacceptingness of his own spontaneous creation, a difficulty she found traceable to a premature loss of belief in a self-created outer reality, describes how she helped him to achieve a healthy reality-relatedness through her acceptance of his treating her as being part of himself—as being his own malleable, pliable, 'lovely stuff', his 'chemicals', which he had created. Winnicott (1945, 1948), in the same vein, has conjectured that the healthy mother helps her baby, in the nursing situation for example, towards an acceptance of external reality through helping him to experience this reality not as something alien to himself but as something self-created. I have described the patient-therapist relatedness during the 'therapeutic symbiosis' phase of therapy as being of essentially this same nature. We see here that

what might be called a form of 'delusional transference'—the patient's reacting to the therapist as being an inanimate, or at least not separately alive, product of the patient himself—is really, in its nucleus, the primeval form of healthy, creative relatedness to external reality, and that this development could not occur if the therapist were unable to become comfortable with this 'inanimate' role in the transference.

A 32-year-old woman patient who had by now progressed far towards recovery from her chronic schizophrenia produced, in a number of sessions over the course of a month, material which illustrated memorably, for me, the point that a person can come to relinquish the oceanic ego-state, and to experience outer reality as such—can bear the loss involved in this development—only by finding an essential sameness between self and outer reality; her experience is, I think, closely comparable with that of Milner's boy-patient.

In the first of the sessions I wish to mention, she was talking about her recently-acquired room-mate, a woman whom I by now knew to personify, in many respects, my patient's own sicker—more paranoid, more self-absorbed—former self, as she had been earlier in her treatment. She spoke with much feeling, including a particularly memorable, childlike naïveté. She told of having been for a walk with another woman patient and of how in the course of their walk they had come upon a little feather lying on the ground, which my patient, Edith, picked up. It so happened, she mentioned to me in her narrative, that her room-mate, an artist, had hung up a work of art she had done, a montage which had on it, among other things, a feather.

When Edith subsequently came into their room, her room-mate, Mrs Simmons, was in there and saw Edith coming in, wearing the little feather on her blouse. Mrs Simmons immediately said, 'Did you take my feather?', accusingly. Edith explained to me that this was typical of Mrs Simmons—that is, it was characteristic of her to think of everything in terms of herself. Edith described how, in essence, she then had patiently but firmly pointed out to Mrs Simmons that no, this was not the latter woman's feather—that Mrs Simmons' feather was there on the montage, and that this was a different one which she, Edith, had just picked up out on the hospital grounds.

From here on in her account to me, Edith's tone took on a kind of childlike naïveté and hesitancy; but she went on determinedly,

though finding it hard to express her thoughts in words. 'When I first came here, I was a little that way,' she said, and this made me smile a bit inwardly, because it was such an understatement. 'Then,' she went on, 'I sort of woke up, and said, "There are so many people here—could be somebody else—we all have almost the same".' She explained that it had been her seeing, in a department store window, dresses which were the same as one she was then wearing, and the same, likewise, as she had seen on various other women at that time during her trips into the community, that was the context in which she had awakened to this realization.

She then added that, in contrast to Mrs Simmons (who had been here in the sanatorium for only two months, in contrast to the several years of Edith's own residence here), when she, Edith, first came here, 'I didn't have anyone to tell me they had a feather'. This was said in a tone of painful deprivation, and I felt pained on hearing it, although this did not seem to be said with any aim of reproaching me for not having made clear to her that I, too, have a feather.

In a session near the end of that same month, she told me, 'Dr Searles, you know I've told you that I very seldom dream. But I had a dream the night before last. You remember that purse I have with flowers on the side of it? I dreamed that I rushed around so much that I lost the flowers from my purse, and I saw another woman pick them up and put them on *her* purse, and I said, [tone of strong protest] "*She's taking my flowers!*"'

She then went on, with much interest, to contrast the feeling she had had in the dream—describing it now in the following way: a sharp intake of the breath, with 'I lost my flowers!'—to the feeling she had had a few weeks previously when, while downtown shopping, she had seen a woman with a purse almost like her own, except that the other woman's purse had flowers on the top, whereas Edith's purse had flowers on the side. Edith described her feeling on that earlier, real-life occasion with a tone of pleasure, 'She has almost the same as mine!' In saying how different from this had been the feeling in the dream, she said, 'I guess I do feel that something has been taken away from me.'

It did not become established in that hour what the 'something' might be, and I was left with this as an unanswered question in my own mind. In the earlier years of our work, she had very often indeed expressed her conviction that she had been robbed; she had been unable for

years to express a feeling of *loss* as such, but instead had felt deliberately robbed, of this or that person or thing, by maliciously inclined other persons including myself.

Then, in a session a very few days later, she described how the previous evening she had been in the nursing office, typing up the minutes of the recent ward-meeting, and Mrs Simmons had felt convinced, erroneously, that the paper Edith was using was from Mrs Simmons' art-tablet. Edith showed her that this was not the case—showed her that the tablet she was using was her own, with some of her own drawings in it, and went on, emphatically but not unkindly, 'Mrs Simmons, you have an illness, and I want you to get over it right this minute! You think everything is yours. I know, because I've been through it myself; I used to think that everything was—well, that everything concerned me, and was mine, and (here Edith's voice, in her telling me, became filled with a sense of loss) was gone.'

I felt that this material revealed how the paranoid person, involved as she had been, years earlier in her treatment, in a state of not-yet-completed ego-differentiation from the outside world, feels robbed of *everything*, and that this process of individuation can go on to completion, and the outside world be found acceptable and no longer made up of one's own stolen former contents, only upon one's finding an essential sameness between self and outer world—symbolized by the feathers, the flowered purses, and the identical women's dresses. By the same token, the patient can become individuated *vis-à-vis* the therapist only after she has come to find that the therapist possesses in reality essentially the same qualities which she has come to know in herself—that her various transferences to him, her various projections upon him, are not devoid of nuclei of interpersonal reality.

We begin to discover that this whole realm of various kinds of delusional transference, or transference-psychosis, can be seen by the therapist to be, and needs to be responded to by him as being, an effort on the part of the patient to build up whole-project interpersonal relationships and a whole-object ego-identity. All these can be seen as part-object phenomena through which the patient successively builds up, bit by bit, through processes of both projection and introjection, a psychological feeling-image of both himself and the mother-therapist as whole persons. One borderline patient experienced this process most explicitly in displaced terms in his relationship with his wife,

clearly a mother-figure to him. In the course of his being absorbed successively with various parts of his wife—her genitals, her breasts, her nose, and so on—each part being the object of his fascinated attention when he was with her, over a period of months he built up to the realization that she was a whole person, and that he, no doubt partly through identification with these various part-attributes of her, was also a whole person.

The extent to which the therapist feels a genuine sense of deep participation in the patient's 'delusional transference' relatedness to him during the phase of therapeutic symbiosis—wherein the patient is reacting to him as being the personification of the Good Mother—is difficult to convey in words; it is essential that the therapist come to know that such a degree of feeling-participation is not evidence of 'counter-transference psychosis', but rather is the essence of what the patient needs from him at this crucial phase of the treatment. A hebephrenic woman who had evidenced intense antagonism towards me for several years eventually came to see me as the personification of the loving potentialities of her mother, and when, one day, as I was leaving her room at the end of a therapeutic session, she said fondly, 'Goodbye, Mother,' I simply replied, with like fondness, 'Good-bye, Betty.' This exchange had no quality of ungenuine role-playing about it; but on the other hand I felt that neither was any pathological misidentification involved. She could as well have said, 'Goodbye, Harold', without any shift in the emotional genuineness of this brief exchange. I felt it then, and have subsequently regarded it, as a landmark in terms of my deeply accepting the 'transference role' of mother to her, and in terms of her acceptance of me in that capacity.

A paranoid woman, who had reached the therapeutic-symbiosis phase of the transference after several years of comparably intense negative transference, suddenly asked in the midst of a highly productive session, 'You mean I own you?' I was not aware that I had been making any comments which could be so translated; but I had seen on a number of recent occasions how, in the midst of fond exchanges about whatever subject, she would suddenly ask, 'Are you proposing to me?', or 'Are you making love to me?' This time, when she asked, 'You mean I own you?', I replied, 'Well, I'm very much attached to you—if you call that owning me, then you own me.' I had never acknowledged so candidly how much a part of her I had come to

feel, and it is noteworthy that this woman, who several years earlier in our work had shown an intensely paranoid reaction against feelings of fond intimacy, showed no such anxiety now. In the course of the next several months she came to express feelings of glowing adoration of me, viewed as an inexpressibly beautiful mother whose body was, the patient felt, interchangeable with her own; and now for the first time I began to get from her a picture of her mother not as multiple, suddenly changeable, and predominantly malevolent figures, but rather as having been, on at least some occasions during the girl's upbringing, a single, whole, healthy, and fond mother to her.

It has been my recurrent experience that one of the necessary developments in a long-delusional patient's eventual relinquishment of his delusions is for these gradually to become productions which the therapist sees no longer as essentially ominous and the subject for either serious therapeutic investigation, or argumentation, or any other form of opposition; rather, the therapist comes to react to these as being essentially playful, unmalignant, creatively imaginative, and he comes to respond to them with playfully imaginative comments of his own. Nothing helps more finally to detoxicate a patient's previously self-isolating delusional state than to find in his therapist a capacity to engage with him in a delightfully crazy playfulness—a kind of relatedness of which the schizophrenic patient had never had a chance to have his fill during his childhood. Typically, such early-childhood playfulness was subjected to massive repression, because of various intra-familial circumstances which I shall not try to elaborate upon here.

One of the ingredients of schizophrenia—in my experience, one of the regular ingredients—is a basically healthy and normal small-child playfulness which, for various reasons referable to the early environment, was early subjected to repression and has long been acted out in manifold ways, often highly destructive ways, by the patient, who is quite unaware of the extent to which he has come to play, in a destructively irresponsible spirit, with the irreplaceable and therefore to-be-cherished-and-preserved relationships and situations in his life. In essence, the therapist has to become able to adapt to the patient's fiddling while Rome burns; at first the therapist endures this, later he comes to be quite comfortable in this setting despite its tragically wasteful aspects, and still later comes to enjoy the music and to share in producing it. At this

juncture the patient, having gained the realization that he is not at heart a malevolent being for wanting to play, becomes interested at long last in putting out the fire, clearing away the rubble, restoring what can be restored, and building anew.

For the therapist thus to succeed, in the long run, in enlisting the patient's active co-operation in the therapy, he must be able to cope along the way with feelings of guilty irresponsibility on his own part. For example, not long ago I felt considerable guilt at discovering that I actually had come to regard with aesthetic appreciation the abundant delusions of a paranoid woman with whom I had long been working. I found myself drinking in, as it were, with appreciation and admiration, productions which my professional conscience told me I should continue, as I had for years, to struggle manfully to investigate with her, or somehow to counter. But as the sessions went on, my enjoyment became less and less tinged with guilt, and it was in this context that the patient came, for the first time, to speak with healthy pride of her own lifelong imaginativeness. I no longer reacted to this imaginativeness as being in any sense an enemy; I could now enjoy it, and participate in it with my own verbalized imaginatively 'crazy'—childishly playful—associations. For a number of years, earlier in her treatment, during what I term the ambivalently symbiotic phase of the therapy, when she had shown a high degree of anxiety and hostility of at times near-murderous proportions, I had surely done much of what Bion, in the following illuminating passages, describes his patient as having 'felt'—supposedly a transference-phenomenon without any basis in reality—that Bion had been doing:

... Throughout the analysis the patient resorted to projective identification with a persistence suggesting it was a mechanism of which he had never been able sufficiently to avail himself; the analysis afforded him an opportunity for the exercise of a mechanism of which he had been cheated. . . . There were sessions which led me to suppose that the patient felt there was some object that denied him the use of projective identification. In the illustrations I have given, . . . there are elements which indicate that the patient felt that parts of his personality that he wished to repose in me were refused entry by me . . .

Associations . . . showed an increasing intensity of emotions in the patient. This

originated in what he felt was my refusal to accept parts of his personality. Consequently he strove to force them into me with increased desperation and violence. His behaviour, isolated from the context of the analysis, might have appeared to be an expression of primary aggression. The more violent his phantasies of projective identification, the more frightened he became of me. There were sessions in which such behaviour expressed unprovoked aggression, but I quote this series because it shows the patient in a different light, his violence a reaction to what he felt was my hostile defensiveness . . . (Bion, 1959).

It is particularly in the realm of playfulness that I have seen clearly before me the technical choice, whether to make a verbalized transference interpretation, or to accept, as it were, the transference-role which the patient is needing me to occupy. Repeatedly I have found that transference interpretations prove to be jarring and stultifying and essentially anti-therapeutic until such time as the patient's experience of shared playfulness with me has become so customary that we can easily regain it, and the more clearly investigative 'work' aspects of what we are doing have become accepted as part of a basically enjoyable enterprise.

Delusional Identification

In this final section of the paper I shall attempt to illustrate the point that, just as the schizophrenic patient's symptomatology comes in the course of treatment to be revealed as consisting in manifestations of psychotic transference, so does this very symptomatology, or at any rate large increments of it, come to reveal an even deeper meaning as evidences of what might be called 'delusional identification'. That is, the patient's crazy behaviour needs to be seen as possessing, along with the psychotic transference root, a root in the form of an expressed identification with the therapist—an identification which, no matter how psychotically distorted, possesses a kernel of reality in terms of the therapist's real personality-functioning. It is essential for us to see this identificational determinant of the patient's illness, for only insofar as we can acknowledge and confirm these nuclei of reality in his identifications with us (no matter how reluctant we may be to discover, or scrutinize with unprecedented directness, the pertinent aspects of our own personality), can we

foster his reality-testing ability and his confidence in that ability.

By way of contrast, Rosenfeld, in his in many respects excellent paper of 1952 entitled, 'Notes on the Psycho-Analysis of the Super-Ego Conflict in an Acute Schizophrenic Patient', to my mind discounts the very real evidences of this particular mother's murderous possessiveness towards her son, the patient, and by the same token Rosenfeld seems unaware of the possibility that he himself was capable of murderous feeling in response to the patient's transference to him as a mother. We see no hint of Rosenfeld's awareness of such a possibility in his treatment of such data as the following:

... Once he said: "How can I get out of the tomb?" I felt here that he implied that in projecting his self, his depression, into me, he felt enclosed by me and so I became a tomb from which he wanted my help to be released ... (Rosenfeld, 1952a).

In a footnote in the same paper, he expresses a point of view which certainly contains a valuable reminder of the essential importance of the intra-psychic realm in the patient—the realm which I have stressed in a recent paper (1963b) concerning the family therapy of schizophrenia. But this passage is also a sample of his tendency to underestimate the etiological significance of early family-environmental factors, as well as the extent to which the schizophrenic patient in therapy is responding to real personality ingredients which the therapist is feeding, inevitably and constantly, into the patient-therapist relationship:

In some papers on schizophrenia particularly by American writers like Pious and Fromm-Reichmann the mother's hostile and "schizophrenogenic" attitude has been stressed. ... In our analytic approach we know that it is futile and even harmful to the progress of an analysis to accept uncritically the patient's attempts to blame the external environment for his illness. We generally find that there exists a great deal of distortion of external factors through projection and we have to help the patient to understand his phantasies and reactions to external situations until he becomes able to differentiate between his phantasies and external reality (Rosenfeld, 1952a).

In another paper (1952b), Rosenfeld writes

... In my opinion the schizophrenic has never completely outgrown the earliest phase of development to which this object-relation [i.e., the patient's relating to the object by projective identification] belongs, and in the acute schizophrenic state he regresses to this early level ...

I consider it essential for us to realize that no one ever does completely outgrow this (or, for that matter, any other) phase of development. When we realize this, we shall no longer overlook the extent to which we too share in the patient's projective-identification mode of relatedness—or, in my terms, we shall be able to see and accept the fact of our own participation in the symbiotic mode of relatedness between the patient and ourself.

Bion never acknowledges the possibility of his making, or having made, a real contribution to his patient's psychotic transference; typical is the passage, in his 'Attacks on Linking' paper (1959), concerning

... what he felt was^a my refusal to accept parts of his personality ...

It is in line with this viewpoint that he says, concerning the origin of the patient's pathological attitude towards linking,

... On the one hand there is the patient's *inborn disposition to excessive destructiveness, hatred, and envy*^a; on the other the environment which, at its worst, denies to the patient the use of the mechanisms of splitting and projective identification ... (Bion, 1959).

When we see the extent to which the environment contributes to the patient's difficulty—when, in particular, we discover the extent to which he is reacting, in his psychotic transference to us, to real and intense sadism, murderous feeling, and so on in ourselves—we find little need, I think, to conjecture that as a newborn baby he possessed some inordinately great, inborn disposition to hostility. Whereas Bion (1959) refers to the patient's '*belief that*^a the analyst strives ... to drive him insane', I have found much evidence, not only in my own work but from various colleagues' reports of theirs, that such a striving is indeed at work in the therapist, among various other intensely conflictual feelings towards the patient, during the so

^a Italics mine.—H.F.S.

difficult ambivalently symbiotic phase of the therapy. It seems to me that relatively abundant transference interpretations might be used by the therapist in an unconscious effort not only to protect himself against symbiotic relatedness with the patient, but also to deny the extent to which his own sadism, so much at odds with his genuinely therapeutic intent, is playing a part in shaping and maintaining the patient's psychotic transference—to deny specifically the extent to which, at the deeper, symbiotic level, he is cruelly and destructively denying the patient access into himself.

In a paper in 1958, I described a number of instances of patients' acting out as being partially traceable to my own previously unconscious urges in the same directions, and mentioned the previous reports concerning this kind of phenomenon by Schreff (1957) and Barchilon (1958). Then in a later paper (1961a), concerning schizophrenic communication, I noted:

Particularly hard for the therapist to grasp are those instances in which the patient is manifesting an introject traceable to something in the therapist, some aspect of the therapist of which the latter is himself only poorly aware, and the recognition of which, as a part of himself, he finds distinctly unwelcome. I have found, time and again, that some bit of particularly annoying and intractable behaviour on the part of a patient rests, in the final analysis, on this basis; and only when I can acknowledge this, to myself, as being indeed an aspect of my personality, does it cease to be a prominently troublesome aspect of the patient's behaviour . . .

It is only more recently that I have become better aware of the *identificational* significance of these events: when, for example, the therapist is able to become aware of the relevant aspect of his personality to which the patient's acting-out behaviour has been a kind of caricatured reaction, he is thereby accepting the patient's struggle to identify with him. In an earlier paper I did note that the schizophrenic patient tends to identify first with those aspects of the therapist's personality which are least acceptable to the latter.

I have already given several instances of a variety of transference psychosis in which the patient endeavours ambivalently to get the therapist to do the patient's thinking for the latter—in line with a family background of a

'know-it-all' parent's doing the thinking during the patient's upbringing. Typically, such a parent has to maintain such a 'know-it-all' demeanour as a defence against inner confusion. I have described the beneficial result of my coming, eventually, to acknowledge freely my own confusion in response to such patients' extremely and often sadistically confusing verbalizations; and I believe that here again we can see in retrospect that the patient's confusion has had, among other determinants, a transference root in the form of a delusional identification with the very real confusion in the parent-therapist. The therapist's becoming able to be aware of and to acknowledge his own confusion helps to resolve the delusional, crazy quality of the patient's confusion. Particularly does it help to resolve the mocking, caricaturing, sadistic, or otherwise destructive aspects of the patient's efforts to identify with the therapist.

In one hour with a hebephrenic man, who was generally either utterly ignoring of me or openly furious at me, and of whose yearning to identify with me I was quite unaware, I once put out my cigarette inside the top of his plastic wastebasket, after having first noted that it was empty. During the following session I was startled when, during one of the customary long silences, the wastebasket caught my eye: there was a black ring around the inside of the top of it where this heavily-smoking man, who had never done so before, had been using the wastebasket as an ash tray as he had seen me do. The potentially destructive nature of his identification startled me, for I felt no assurance that he took care, as I had, to make sure that the wastebasket was not full of paper.

Incidentally, I did not attempt a transference-interpretation at this point, for from long experience I knew that it would be like talking into the wind; but the incident had a long-run usefulness in helping me to be more alert to his need and his efforts to identify with this therapist of whom he ostensibly wanted no part whatever.

In my monograph concerning the nonhuman environment I presented, as an instance of the schizophrenic patient's inability to distinguish clear boundaries between his self and his non-human environment, the following incident from my work with a hebephrenic woman:

. . . [She] shockingly conveyed to me the statement that the whole left side of her head "is gone . . . caved in", speaking as if in reference to an inanimate object; one sensed

her own horror and despair about this . . . (1960, p. 148).

In the years that have passed in my work with this woman since the above-noted incident occurred, two additional significances of this same symptom have come to light. About five years later, at a time when she had long since become—both subjectively, so far as one could determine, and objectively, as measured by my and other persons' responses to her—fully human, I made the following note:

The work with Pauline continues to show [as had been true, by that time, for many months], most prominently, her making clear her ambivalent efforts to achieve, and to avoid, a symbiotic relatedness with me as a representative of her father . . . [For example] about three weeks ago when I came up on the fourth floor to see another patient there, and stepped into Pauline's room for just a moment while the other patient was getting ready, Pauline once again made some reference to the left side of her head's being gone, or some similar terrible organic defect which I cannot precisely remember at the moment. This was almost exactly the kind of thing which she had expressed not very long after her admission here, and I found now that I reacted to it privately with a completely different connotation: I saw it as a very formidable effort to draw me into a kind of solicitude and a kind of taking over her life for her in a symbiotic fashion. Actually I did feel solicitude for her, *but saw it, much more this time than I initially did, as a transference manifestation.*

My different reaction this second time was probably due more to the change which had occurred in her—in terms of increased 'humanization'—than to an increase in insightfulness on my part over the intervening five years. At that earlier time such communications had emerged from such a 'nonhuman' over-all demeanour, and in such a vocal tone of horror and otherworldly despair and eeriness, as to make the listener (whether me or other personnel members) draw back in shock, and be quite blinded to any potential interpersonal-transference significance.

Slightly more than three years later still in our work, she was sitting nearby and looking at my face with a kind of private amusement, as I was saying something—I can't recall what. She asked, 'Is it all going to fall off?—Is it that bad?', rubbing her forehead and the top of her

head as she spoke in such a way as to convey the idea that they—these areas of her body—were all crumbling. Her tone in asking this was a semi-serious one, and to this extent conveyed a genuine delusional experience; but her tone was also a semi-amused one. I replied, 'You do feel that I'm awfully *serious*, eh?'. She said, with warm and open amusement and without any tinge of delusional anxiety, 'Yes.' I had been aware for many years that among the personal eccentricities which survived the ravages of my personal analysis are a chronically worried look and a tendency to take everything too seriously; but I had not been aware that some of this patient's delusional behaviour was a reaction, in part, to this aspect of my personality. Each of her parents possessed this quality in abundance, which no doubt was relevant here; but I felt it better simply to acknowledge this real aspect of myself. To have made some transference interpretation at that juncture would, I think, have placed needless distance between her and me, and would have vitiated my corroborating her own reality appraisal of the here-and-now situation.

The sequence which I have described, as occurring over the years of my work with this woman, is but one among many analogous ones which emerged as she became progressively human and progressively able to distinguish between literal and metaphorical meanings. As another brief instance, whereas there were occasions relatively early in our work when she seemingly perceived me as being inanimate—once, for example, looking at me in a kind of *uncanny* astonishment as I smoked a cigarette, and exclaiming to *herself*, 'What makes it smoke?'—several years later this bizarre perception of me devolved into a querying of me, clearly at this time as a transference representative of her compulsive father, as to whether I considered the way I lived to be really living. Her seeing me as being, in this figurative way, 'dead', contained, despite the element of transference distortion and exaggeration, a sufficiently realistic view of some of the aspects of my own compulsively work-oriented life for me to acknowledge the validity of the view of me which she was expressing.

At the end of one of the sessions during this same later period in our work, when I was about to go on a week's vacation, I commented, 'Well, I'll see you a week from Monday.' She replied in an ironic tone, as I was then starting out the door of her room, 'Try again.' My first thought was

that she meant by this that in her opinion our efforts during the session had been futile—as she had been indicating in many ways, both verbal and non-verbal, for years. But then another possibility occurred to me, and I asked, ‘Do I sound defeated when I say that?’, which she corroborated in a tone of delighted warmth and closeness. I had long known that she had viewed her father as being a disappointing quitter; but she had finally got the message across to me as to how defeated I, as I now realized in retrospect, often appeared and indeed felt, though I characteristically tend to repress such feelings. I believe it correct to think that the tremendous despair which this woman had shown during the first several years of our work, and which she acted out in myriad hebephrenically-fragmented forms of personality functioning, consisted in large part in a delusional identification with the despairing aspects of her father, her mother and, as the treatment relationship developed, myself.

A few months ago, a paranoid schizophrenic woman said to me, in reply to a verbalized interpretation I had just suggested to her, ‘When you talk to me like that, I feel that I’m going to be led to the edge of the world and the people are going to decide whether I’ll have to jump off or not’. I had known her to be living for years in a chaotically and terrifyingly delusional world, and when she said this I was momentarily awed, once again, by this glimpse

into the vastly terrifying world in which she lived. But then this other viewpoint, concerning the possibility that I had unwittingly contributed to such a degree of delusional experience on her part, occurred to me, and I asked simply, ‘Do you mean that I sound so portentous?’, and she replied, even more simply, ‘Yes’. Even more recent developments in our work have suggested that her having been living for so long in a terrifying psychotic world has been due, in part, to her delusional identification with what she has now come to call her ‘fraidy-cat’ therapist, who tends somewhat—as did her mother to a very great degree—to hide his own fearfulness behind the demeanour of the strong, calm parent-therapist.

In summary, it is my experience that even the most other-worldly, even the most ‘crazy’, manifestations of schizophrenia come to reveal meaningfulness and reality-relatedness not only as transference reactions to the therapist, but, even beyond this, as delusional identifications with real aspects of the therapist’s own personality. When we come to see such meanings in the schizophrenic individual’s behaviour, we come more and more to realize not only that he is now in the human fold but that, if only there had been someone all along wise and perceptive enough to know, and brave enough to acknowledge, he has never really been out of it.

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PRIMITIVE OBJECT RELATIONSHIPS AND THE PREDISPOSITION TO SCHIZOPHRENIA¹

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One of Freud's proudest achievements was the transformation of the therapeutic relationship which takes place in psycho-analysis into a tool of scientific investigation. Freud also believed that 'the future will probably attribute far greater importance to psycho-analysis as the science of the unconscious than as a therapeutic procedure' (Freud, 1926). Nevertheless in recent years the importance of clinical research has been underestimated and a growing cleavage has developed between the researcher and the clinician. Scientific investigation, in common with all other forms of human group endeavours, is subject to moods as well as to the whim of fashion, and this has led to some disappointment with the contribution of psycho-analytic psychiatry to the problem of schizophrenia, which has resulted in a turning away from the investigation of the psychology of schizophrenia, with the hope that biochemistry and neurophysiology will solve its riddle.

Let us consider the relation between clinical research in psychiatry and the investigations of basic science. Every generation of psychiatrists seems to have faced this problem. I quote from a lecture given by C. Macfie Campbell (1935): 'The prestige attached to research dealing with the impersonal process of diseases leads some to hold that further progress in psychiatric investigation must await advances in the basic sciences. It is dangerous, however, for psychiatry to take this dependent attitude towards the solution of its special problems and to demand too much from other disciplines . . . Human nature cannot be adequately analyzed by the methods of chemistry and physiology and general biology.'

Some knowledge of the history of science in general, and of medicine in particular, is useful,

since it puts these issues in their proper perspective. We, in our vanity, tend to believe that the problems of our day are unique. It is understandable that we are impressed with the rapid expansion of biochemistry in its application to medicine, which in a short time has transformed some aspects of medicine from an art to a science. But let us suppose that biochemistry had achieved its present state of maturity when medical knowledge was no further advanced than it was in the eighteenth century, when the description and differentiation of clinical syndromes as we know them today were just beginning. Had biochemistry been available to the clinician of that day, it could not have been applied, since the medical syndromes themselves had not yet been sorted out. It would have been as if botany had adopted a physical-chemical theory of living organisms before it had established a systematic typology (Nagel, 1961). In some respects psychiatry is at a stage comparable to medicine in the eighteenth century, in that modern clinical observation is still in its infancy, as it was born with the work of Kraepelin, Bleuler, and Freud. The application of basic science is possible only when there is clinical knowledge. It would be serious indeed if the clinician were to relinquish his investigative role to the basic scientist.

The tendency to undervalue and neglect clinical research is only part of the problem. As previously mentioned, there has been some discouragement with psycho-analytic therapy as an investigative method, and this has resulted in premature attempts to substitute the methods of the more precise disciplines. The history of science documents the phenomenon of the awe of the mature sciences that is experienced by those whose own discipline is less precise. The

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awe of success is something with which we are all familiar in our own lives; science, as well as the individual, adopts a similar response—imitation of the more mature. Nagel (1961) notes the adverse effect of the attempt to reduce prematurely the less advanced to the more precise science, since this diverts needed energies away from what are the crucial problems at a particular period in a discipline's expansion. To provide an example: Newton's influence on the chemistry of his day was catastrophic (Bronowski and Mazlish, 1960), for mathematics became the model of all sciences, and chemists, in their attempt to imitate Newton, dropped their own more appropriate techniques. Advances in chemistry in England came entirely from outside the Royal Society, because the scientists within the Society attempted to apply mathematics to problems that could not yet be dealt with in that way.

The awe of Newton's systematic description of the physical universe influenced medicine as well. For shortly after Newton's discoveries, it became fashionable to construct speculative systematic explanations of diseases which proved to be sterile *since they were divorced from direct clinical observation* (Garrison, 1929; Guthrie, 1946).

Within the last few decades physics has undergone a second major revolution, and those of us whose disciplines are less mature have been subjected to similar influences. We are bedevilled with the trend towards quantification before we know what we are quantifying or have the instruments with which to measure. And the theoretical achievements of physics are imitated in our day, as in Newton's, by the development of highly abstract theoretical systems which tend to become a form of scholasticism as the abstractions become increasingly removed from observation. Psycho-analysis also has not been entirely immune from this tendency.

Schizophrenia is not a disease entity, but represents a symptom complex which could be considered 'a final common pathway', that is, the final outcome of a variety of pathological conditions (Jackson, 1960). In this sense schizophrenia is comparable to the eighteenth-century diagnosis of dropsy. In order to apply the more precise techniques of the biological sciences to the problems of schizophrenia things must first be sorted out. The detailed clinical observations that are the daily work of the psycho-analytic psychiatrist should help to sort

out the variety of different clinical syndromes that we call schizophrenia. Careful psychological observations of the schizophrenias and related disorders may uncover clues as to where a purely psychogenic as well as a purely biological hypothesis falls down. It is my thesis, therefore, that the more general or inconclusive observations gained from psycho-analytic psychiatry must prepare the way for the application of the more precise techniques of biological investigation. To paraphrase what has been said in another context, although clinical description fails to satisfy the standards of precision achieved by modern physics, it is prepared to present inconclusive evidence rather than no evidence at all (Sommerhoff, 1950).

For the past three decades, psycho-analysts have become increasingly better acquainted with the group of patients who fall between the designation of neurosis and that of psychosis. It is customary to refer to these patients as borderline cases. These individuals demonstrate a wide variety of symptom complexes: they may be eccentric, withdrawn people who could be properly called schizoid; or they may be depressed, addicted, or perverted, or any combination thereof. You may question whether such a wide variety of differing symptomatic syndromes can be brought together under a single heading. If we consider the issue, not in terms of the presenting symptoms but in terms of the similar nature of their object relationships, we find many threads uniting these seemingly disparate disorders.

The conflicts of these people in relation to external objects bear a striking similarity to those observed in the schizophrenic patient. As with the schizophrenic patient, there is a significant disorder in the sense of reality. This tends, in the borderline case, to be more subtle than and not so advanced as in schizophrenia. But my principal reason for considering this group to be homogeneous is that they develop a consistent and primitive form of object relationship in the transference. This will be described in detail later, but for the moment let me say that it more closely resembles the transference of the schizophrenic than that of the neurotic patient. As we learn more of psychopathology, we should expect to find that nosological entities will be based not so much on overt psychopathologic but more upon the less overt psychopathologic structure. I am using the term borderline here to designate a structural and not a symptomatic diagnosis.

The differences between this group and the schizophrenias also need to be emphasized; for in them, unlike most schizophrenic patients, we do not observe widely fluctuating ego states. There is, however, evidence of a certain stability of character and, as Gitelson (1958) has emphasized, their defences operate exceedingly well. They may at times regress into psychosis, but as a rule this is a circumscribed psychosis; it does not involve the total personality. They may, for example, develop ideas of reference, but they do not develop a major schizophrenic syndrome as described by Bleuler (1911) with a relative abandonment of object relationships. Although their difficulties with other people are serious, they tend to retain their ties to objects and, as Gitelson has expressed it, they 'place themselves in the way of object relationships'. It should be noted, then, that I am using the term 'borderline' not, as it has sometimes been used (Knight, 1953; Zilboorg, 1941), to refer to incipient or early schizophrenia.

The fact that the pathology of borderline cases tends to be relatively stable and that they tend to maintain object relationships makes it more possible to use the transference relationship as an investigative tool. It is both their closeness to and their difference from the schizophrenias that provides a certain contrast that may prove illuminating.

I shall describe in considerable detail my own observations as well as those made by other psycho-analysts who have treated these patients. I do not claim any originality for these observations, since the salient features have been described before; I shall draw heavily upon the work of Hendrick (1936), Helene Deutsch (1942), Jacobson (1954), Klein (1948), Fairbairn (1940), Winnicott (1945, 1951), and Gitelson (1958). I have tended in my own clinical work to specialize in this group and have augmented my direct observations by a larger series of cases whose treatment I have supervised (at the Beth Israel Hospital), so that I have a strong degree of conviction that what I shall present is accurate.

Hendrick and Helene Deutsch were among the first to explore psycho-analytically this group of disorders. Both authors were aware that they were observing a group of character disorders which appeared to be more closely related to schizophrenia than to the neuroses. Although their clinical material was by no means identical, both believed that they were observing a developmental disorder of the ego that placed a special strain on the processes of identity and

identification. Helene Deutsch's (1942) description of the 'as if' personality has become a classic. She describes a group of people who superficially appear to be normal but whose life lacks genuine feeling. They are able to form relationships, but these are based more on identification than on love. As such their object relationships have a primitive quality corresponding to the child's tendency to imitate. Their sense of identity is borrowed from the partner, so that their emotional life lacks genuineness. Not all borderline patients are 'as if' characters; some display other psychopathological mechanisms; but let us assume that the 'as if' trait is a syndrome within the borderline designation. Deutsch was not certain whether she was describing a personality type predisposed to schizophrenia or whether the symptoms constituted rudimentary symptoms of schizophrenia itself.

Hendrick (1936) described three different character types—the schizoid, the passive feminine man, and the paranoid character. He stressed the fact that these three had a fundamentally different ego structure which was closer to schizophrenia than to the neuroses. He understood this structural pathology to result from a failure of the normal maturational process. He noted the prominence of primitive destructive phantasies which interfered with the ego's executant functions, and offered an explanation which I believe can be confirmed by recent observation. Hendrick speculated that these primitive, infantile, aggressive phantasies would normally have been terminated by a process of identification which had failed to occur.

I am using the term borderline to refer to a symptomatically heterogeneous group of patients who nevertheless form a nosological entity because of their similar transference relationships. In the older literature the term 'schizoid personality' was employed to designate a similar nosological group, placed somewhere between neurosis and psychosis. This character type was considered most predisposed to develop schizophrenia. The schizoid individual is one who is described as aloof, irritable, and unable to form close relationships. It was further believed that such an individual was unable to form a transference. We now know that this view is incorrect. The withdrawn, aloof person is only one of the very many personality types who may become borderline. These patients do form a transference relationship, which is frequently extremely intense, but differs signi-

ificantly from that formed by neurotic patients. This transference has specific features which I now recognize as a useful operational method of diagnosing the borderline patient.

The relationships established by these people are of a primitive order, not unlike the relationship of a child to a blanket or teddy-bear. These inanimate objects are recognized as something outside the self, yet they owe their lives, so to speak, to processes arising within the individual. Their objects are not perceived in accordance with their 'true' or 'realistic' qualities. I have borrowed Winnicott's concept of the transitional object, which he applied to the child's relation to these inanimate objects (Winnicott, 1951), and have applied this designation to the borderline patient's relation to his human objects. The relationship is transitional in the sense that the therapist is perceived as an object outside the self, yet as someone who is not fully recognized as existing as a separate individual, but invested almost entirely with qualities emanating from the patient. We can place this form of object relationship midway between the transference of the neurotic (where the object is perceived as outside the self, and whose qualities are also distorted by phantasies arising from the subject, but the object exists as a separate individual), and the experience of certain schizophrenics, who are unable to perceive that there is something outside the self. For these reasons I believe the term transitional to be accurate, as it truly designates a transitional stage.

I will describe this state of affairs in the borderline patient in greater detail. The relationship of the borderline patient to his physician is analogous to that of a child to a blanket or a teddy bear. We can observe that there is a uniform, almost monotonous, regularity to the transference phantasies, especially in the opening phases of treatment. The therapist is perceived invariably as one endowed with magical, omnipotent qualities, who will, merely by his contact with the patient, effect a cure without the necessity for the patient himself to be active and responsible. We may question why this should be considered characteristic of the borderline patient, since most people attribute to their physicians certain omnipotent powers, especially if their need is great. The wish for an omnipotent protector may indeed exist in everyone:

the difference here resides in the fact that the borderline patient really believes the wish can be gratified.³ We shall find that the borderline patient's belief in the physician's omnipotence corresponds to a belief in his own omnipotent powers, for he thinks that he can transform the world by means of a wish or a thought without the necessity for taking action, that is, without the need for actual work. He is, in contrast to the neurotic patient, unable to perceive that after all the physician is only a human being like himself; the idiosyncrasies of the physician's personality, which make the physician a separate individual, do not seem to register. I am aware that many borderline patients share with some schizophrenics an uncanny ability to perceive accurately some aspects of the physician's personality. This perception, no matter how accurate, mistakes the part for the whole, as these patients are not able to place what they note in its proper context. For example, Hendrick (1936) observed that the paranoid is indeed correct in perceiving the hostility in others, but that that is all he is able to perceive. It is striking that, regardless of the many different personality types represented by a group of residents treating these patients, this phantasy of omnipotence remains uniform. It is soon found that the patient is unable to perceive the therapist as he is, for he is unable to perceive himself as he is. The omnipotent therapist corresponds to the omnipotent self-image; so that although the therapist is perceived as outside the self, he is endowed with qualities identical with those of the self, and the distinction between self and object is only partial.

We need to describe in greater detail the self-image of these patients, which is also strangely uniform. It too is transitional in the sense of standing midway between a state of affairs where there is an absence of the sense of self, as in certain psychotics (Jacobson, 1954), and one where there is a distinct sense of self. There is a fusion or confusion of the sense of self with the object; and the object is perceived in accordance with certain infantile phantasies concerning the mother. For the picture of the self is regularly composed of two portions, one that of a helpless infant, the other that of someone who is omnipotently giving or omnipotently destructive. The patient attributes the omnipotently bene-

³ A phase analogous to the transitional object relation where there is lack of self-object discrimination, and a struggle accepting the loss of omnipotence, occurs in the analysis of neurosis, especially in the terminal

phase (Zetzel—personal communication). There, however, in contrast to the borderline case, distinction between transference and the therapeutic alliance is maintained (Zetzel, 1956).

volent or omnipotently destructive aspect of the self-image to the physician. He in turn is left with the feeling that he is nothing but a helpless child, whose identity may be lost in the object. I say 'he', but it is also remarkable here that this process occurs in both sexes.

The analogy of this human object relationship to the child's relation to the blanket or teddy-bear, though not to be taken literally, nevertheless still demonstrates further points of similarity. For if the therapist is able to establish himself in the patient's mind as benevolently omnipotent, rather than destructively omnipotent, it is not uncommon for the patient to believe he is safe as long as the contact with the therapist prevails. This is of course an illusion. It is as if in some magical fashion the therapist will protect him from the dangers and vicissitudes of life, as the child feels safe when he has his teddy-bear in bed: the patient has the illusion that he is not actually 'in the world' as a separate object, and that the therapist in some way stands between him and the dangers of the outside world. This belief is reminiscent of the young child's belief that as long as he is with his mother he can come to no harm. As with a blanket, the therapist must be there; but as compared with an inanimate object, the therapist is less subject to control. Blankets may also be mislaid and lost, but the threat of losing the human object is greater. This aspect of the relationship is reflected in the borderline patient's obsessive need to be assured of the constancy of the physician. It can be seen that the dependence on external objects is enormous, if the patient believes his fate to be in the hands of another. Yet this dependence is usually denied by means of an illusion of self-sufficiency.

At times it seems that the patient feels that he and the therapist are the only people in the world. Hendrick (1951) has described this one-to-one relationship as dyadic, in contrast to the later phase of object relationships associated with the oedipal stage, which he called triadic. This excessive dependence on the object of the therapist and the lack of appreciation of his qualities as a human being lead to a certain exploitive tendency. Winnicott (1945) has described this as analogous to the preoccupation of the young child who is ruthless and is simply interested in gratifying his needs. This aspect of primitive object relationships has also been described by Anna Freud (1952), who made a special point that the small child is concerned more with care aspects than with specific people.

The therapist is endowed with qualities that are in accordance with the patient's own primitive and undifferentiated self-image which is composed in part of both omnipotently creative and omnipotently destructive portions. There is then constant danger that the omnipotently benevolent and protective physician may be transformed into his opposite. These people experience the harrowing dilemma of extreme dependence coupled with an intense fear of closeness. It is the familiar central conflict in both borderline and schizophrenic patients. The differences between these groups lie not so much in the content of the conflict as in the psychic structures available to mediate the conflict.

If one is faced with the belief that one's safety in the world depends on another human being, and this is coupled with the conviction that closeness to this other person will be mutually destructive, the solution lies in maintaining the proper distance. This dilemma is beautifully illustrated by Schopenhauer's famous simile of the freezing porcupines, quoted by Freud in his *Group Psychology* (1921, p. 101): 'A company of porcupines crowded themselves very close together on a cold winter's day so as to profit from one another's warmth and to save themselves from being frozen to death. But soon they felt one another's quills, which induced them to separate again, and the second evil arose once more. So that they were driven backwards and forwards from one trouble to the other, until they discovered a mean distance at which they could most tolerably exist.'

The quills of the porcupine correspond to the anger of these patients, which is, like the quills, mostly defensive. Although mutual destruction is feared, when we examine their anxiety closely we recognize that the true danger arises not so much from their aggression, as from the more tragic fact that they fear that their love is destructive (Fairbairn, 1940). Fairbairn observed the phantasy that can be easily confirmed: to give love is to impoverish oneself—and to love the other person is to drain him. We note that hostility is expressed easily. It is only after a long and successful treatment that we can observe the genuine expression of positive or tender feelings.

It may be thought that what I have described is to a certain extent present in all of us, that a fear of closeness may be part of the human condition. This would appear to weaken the case that it is a specific characteristic of transitional

object relationships. If we grant that what has been described is part of the transitional object relation, and if what I have been describing may be observed in all human beings, then how can it be maintained that transference based on a transitional object is diagnostic of the borderline group? Let me attempt to resolve this question: the growth of object love is a developmental process co-determined by the development both of the instincts and of the ego (A. Freud, 1952). There are three phases of object love that have been implicit in this discussion. We assume that the earliest phase exists in the young infant who responds to the mother but is as yet unable to make any psychological distinction between the self and the object; the middle stage has been described as the stage of the transitional object relation; the more mature stage of object love is the stage where there is a distinct separation between self and object. This is, of course, a condensed and over-simplified view, but it should suffice to demonstrate a developmental sequence in the growth of object relations. This view is not merely inferred from the observation of adults, but is also based on the direct observation of children. For example, Mahler (1955) has convincingly demonstrated that in the development of the normal child there is a continuing phase where self and object are imperfectly differentiated: the stage which she has described as symbiotic corresponds in a general way to what we have described as the transitional object. Further evidence that the stage of the transitional object is an advance beyond the earliest stage of object relations is presented by Provence and Ritvo (1961). They are able to confirm the observations of Piaget and others (Rochlin, 1953) that the child's relationship to inanimate objects parallels his relation to the human object: infants who were institutionalized and deprived of mothering did not develop transitional objects. Their observations suggest that a certain degree of gratification from the maternal object has to be present for the child to reach the stage of the transitional object: the stage of the transitional object is not therefore the earliest stage of object relations.

Freud wrote (1930):

... in mental life, nothing which has once been formed can perish—[that] everything is somehow preserved and [that] in suitable circumstances (when, for instance, regression goes back far enough) it can once more be brought to light.

Applied to our immediate discussion, we would then say that remnants of earlier, more primitive stages of object relations are present in all of us to a greater or less degree. The difference between the borderline and the neurotic patient resides in the fact that for the most part the psychic development of the former became arrested at the stage of the transitional object, whereas the neurotic patient has passed through this stage, to develop love for objects who are perceived as separate from the self. It is true that, in the neurotic, remnants of these earlier stages may be found, and this is especially so when we look at certain creative processes where we can observe feelings of fusion and merging of the self with objects similar to those described in borderline patients. This also is true of certain religious experiences, for, as Freud noted (1930), the experience of religious ecstasy may be felt as an oceanic fusion and may exist in otherwise normal persons. William James (1902) describes the conviction of the religious person as a belief that no harm can befall him if he maintains his relation to God. This relation is also experienced as a partial fusion and mingling of identities, which seems quite similar to our description of a transitional object relation.

We cannot avoid using the concepts of fixation and regression. Freud's analogy of the deployment of an advancing army, used to describe instinctual fixation and regression (quoted by Knight, 1953), is particularly apt. For in describing the deployment of an army we introduce a quantitative factor, that is, where are most of the troops—are they in the forward, middle, or rear positions? In the borderline cases we would say that most of the troops are at the position of the transitional object, though a few may have achieved a more advanced position. In the neurotic individual, most of the troops have advanced beyond the position of the transitional object, though a few may be left behind.

I have now to return to the larger question implicit in the title of this paper, that is, the relation of these clinical observations to the problem of schizophrenia. I have stated earlier that observations of the borderline patient may help to clarify certain nosological issues and may indicate where purely psychological or purely biological explanations fail. We have to consider the foregoing material in accordance with this larger problem.

Clinical observations suggest that a nosological

distinction be made between two groups of patients: one consists of those individuals whose defences are unstable, who demonstrate fluctuating ego-states, who appear to possess a capacity to suspend or abandon relations to external objects, as occurs normally in a state of sleep. We would say that in these cases the illness appears to involve almost the total personality. In the contrasting group, of which the borderline patients form a portion, psychotic illness appears to occupy only a part of the personality, and the defences of the ego are more stable; these patients appear to be unable to suspend or abandon their relations to external objects in a total sense. Their relation to external objects is impaired and distorted but somehow maintained.

The presence of psychosis is defined as loss of ability to test reality. We know that the failure to deal with reality is a consequence of an altered ego function (Hendrick, 1939); it is the consequence and not the cause of a psychotic deficiency (Federn, 1943). We know that the testing of reality depends upon the fact that in the ego's growth a distinction has been made between self and object (Freud, 1925). It is only when this distinction has been made that there can be a differentiation of what arises from within from what arises from without. In an earlier paper (Modell, 1961) I have presented some clinical observations that suggest that there are degrees of alteration of this function of testing reality that correlate with the degree to which self and object can be differentiated. Self-object discrimination is a dynamic process with no absolute fixed points. As I have described, the borderline transference is based on a transitional object relation where there is some self-object discrimination, but where this discrimination is imperfect. That is, the therapist is perceived as something outside the self, but is invested with qualities that are identical with the patient's own archaic self-image. Reality testing, then, is a process where degrees of alteration of functioning can be observed. If the definition of psychosis is based on the loss of the capacity to test reality, it would then follow that the point at which we designate a phenomenon as psychotic is not a fixed point but a somewhat broader area.

The dynamic, that is the mobile nature, of this process needs to be emphasized. For example, borderline individuals may at certain times in their dealings with others be able to maintain a sense of reality. In the transference relationship this function may undergo a regression which

may last only during the therapeutic hour. In these instances, the distinction between self and object that has been maintained, although imperfectly, becomes obliterated. When this occurs the patient could be said to be technically psychotic in the transference situation. This dynamic regression observed in the transference is at times unfortunately not limited to the treatment hour, and may extend into the patient's life. When this occurs we should judge the patient to be not only technically but clinically psychotic. The step backward that a borderline patient needs to take to be judged clinically psychotic is a short one. This step may be adequately understood in terms of a dynamic and structural psychological regression involving a further loss of self-object differentiation. If the etiology of what we call psychosis results from a further loss of self-object differentiation, there is no need to introduce the hypothesis that the induction of psychosis in these patients is the result of a neurochemical process that operates at the point in time at which the psychosis becomes manifest. The crucial etiological issue here is not the emergence of psychosis, but those factors that have interfered with the growth of the ego, which in turn have resulted in the imperfect self-object differentiation. For the etiology of psychosis in the borderline group would appear to result from a developmental disorder of character that leads to an arrest of object relationships at the stage of the transitional object.

We know that the growth of object relations is the result of the interaction of two broad forces: the one relates to the quality of mothering, and the other to the child's biological equipment. Now it is conceivable that inherited or prenatally acquired variations in the biological equipment may significantly interfere. I have previously reviewed some aspects of this problem (Modell, 1956). For example, it has been observed that some infants appear to be born with an unusual sensitivity of their perceptual apparatus. It is conceivable that such an oversensitive child would find the stimulation of nursing less pleasurable than a normal child. If this were true, a biological factor in this instance could conceivably interfere with the child's capacity to form his first object relationship. This is similar to Hartmann's (1952) suggestion that neutralization of instinctual energy is a biologically determined process, and an inherited impairment of this process could also lead to an impaired capacity to form object relationships. Jones

(quoted by Zetzel, 1949) proposed that some individuals have a relative incapacity to tolerate frustration and anxiety. He thought that this might be an inherited feature similar to intelligence. Others, such as Greenacre (1941), have suggested that the operation of biological processes may not be transmitted in the chromosomes but may be the result of specific prenatal or birth experiences. She suggested that a traumatic birth experience may lead to an excessive level of anxiety in the development of the child.

We must admit that all of these proposals, while plausible, remain unproven. But I mention them to indicate that if we do establish a biological etiology in the borderline psychotic group, it will refer to those factors that interfere with the establishment of object relations in infancy and hence lead to an arrest of ego development. Although those biological factors that interfere with the growth of object relations remain unproven—though probable—there is considerable clinical observation tending to support the view that some failure in maternal care is present in all those cases where there has been an arrest of the growth of the ego. This failure may take many forms. It may be actual loss of the mother or separation from the mother, as Bowlby (1961) has emphasized. However, from my own clinical experience, it does not seem to have been actual physical loss of the mother, but a failure of mothering which took more subtle forms. In some cases the mothers were unable to make emotional contact with their children, as they themselves were severely depressed or even psychotic. In others it was possible to reconstruct the fact that there had been significant absence of the usual amount of holding and cuddling. In still other patients the physical care appeared to have been adequate, but there was a profound distortion in the mother's attitude towards the child. For example, a mother's incapacity to perceive the child as a separate person may induce a relative incapacity on the child's part to differentiate self from object. We are not, however, in a position to state that these deficiencies of mothering will in themselves, without the contribution of other biological factors from within the child, lead to an arrest of the ego's growth at the stage of the transitional object.

I wish to emphasize that the crucial issue in the borderline patient and the related group of circumscribed psychoses is not the onset of the psychosis or psychotic-like condition, but is the

developmental arrest that results in the impaired differentiation of self from object. A loss of reality testing that defines the onset of psychosis is but a slight further accentuation, or regression, of an already impaired characterological formation.

The difference between the group which we have just described and the 'other schizophrenias' appears in a certain instability of defences resulting in fluctuating ego states, and culminating in the ability to suspend relations with objects in a manner analogous to dreaming while in the waking state. It is my impression that these two groups are separate nosological entities, and that a member of one does not become a member of the other. I interpret this observation to suggest the fact that something must be added in order to permit an individual to sever his relations to the external world by means of a dream-like withdrawal. As Campbell (1938) stated it—'I prefer to think of the schizophrenic as belonging to a Greek letter society for which the conditions for admission remain obscure.' I suggest that the capacity to suspend relations to external objects, which the borderline group does not possess, is determined by the presence of something that is unknown, and something which may well be of biological and not of psychological origin. Some can gain admission to this fraternity, others simply cannot, no matter how hard they try.

A biological hypothesis seems to me unnecessary to explain the onset of psychosis in the group whose defences appear to be stable, that is, in the borderline group; in my opinion, however, something must be added in order to develop a 'major schizophrenia'. I do not believe that a purely psychological explanation of this 'something' is adequate. I am aware that the differences between the borderline and schizophrenic groups have been explained in terms of the strength of the defence structures operating in the former group. For example, Federn (1947) has suggested that the schizoid personality protects the person from becoming a schizophrenic. Glover (1932) believed that a perversion which may frequently be observed in the borderline group also acts as a prophylaxis against psychosis and is, in his words, 'the negative of certain psychotic formation'. If we could assume that the strength of defences was entirely psychologically determined, we would have no need to introduce a biological hypothesis. The argument that certain defensive structures protect against a greater calamity

seems to be reasonable, but I believe such an assertion begs the issue. For we are left with the question why these defences are effective: what is it that permits such defences to be maintained? If we wished to maintain the argument for a purely psychological determination, we might say that the strength of the defences is simply the consequence of the degree to which the ego has matured. The gist of this argument would be that the difference between the schizophrenic and the borderline is the result of the fact that the degree of arrest in ego development is more extensive in the schizophrenic patient, perhaps as a result of an even greater disturbance in the early mother-child relationship. This appears to be a plausible argument; but the fact that many schizophrenias do not develop until mature adult life negates this hypothesis. For observation does not show that ego development in the schizophrenic is necessarily more primitive or more severely arrested than that of the borderline patient. We know that individuals who develop schizophrenia are able to marry; in many instances they have distinguished careers prior to the onset of their illness. It is inconceivable that such accomplishments could be possible in an individual whose growth had been arrested at the earliest levels. Schreber (Freud, 1911) was a distinguished jurist and was 37 years old at the time of his first illness. There is, therefore, no evidence that the ego-arrest of schizophrenic patients is in all instances greater than in borderline cases. I would suggest, therefore, that it is not possible to explain the differences between the borderline and the schizophrenic groups on purely psychological grounds.

Clinical observations suggest that we are dealing with at least two separate problems. One is a problem of character formation, which is a consideration of those factors that have interfered with the ego's growth so that love relations become arrested at the stage of transitional objects. The other is probably a biological problem—What is it that is added to permit an individual to suspend his relations to his love objects? Whether the character development of the borderline and schizophrenic patient proceeds along separate or similar lines is a question that awaits further exploration. We would suspect from what can be reconstructed from the history of schizophrenic patients that their love relationships proceeded no further than that of the transitional object; that is, it is quite likely that they are unable to make a complete separation between themselves and their love objects.

There is undoubtedly wide individual variation concerning the age at which 'that certain biological something' is added. It is likely that the early presence of this hypothesized biological process in the schizophrenic group would produce certain divergences in character development as compared with the borderline group. The consulting psychiatrist, however, rarely has an opportunity to see a schizophrenic patient prior to the onset of his psychosis, so that there are few clinical data that can be utilized to clarify these questions. I was very pleased to learn that a research project headed by Makkay at the Judge Baker Center will attempt to differentiate the character structure of borderline children from that of children who might later develop schizophrenia.

Although we are unable to state to what extent the prepsychotic development of the schizophrenic is similar to or different from that of the borderline patient, it is likely that an arrest of the development of object relations at the transitional level is a predisposing factor for the development of schizophrenia. We might hypothesize that the unknown biological something that must be added will result in schizophrenia only where the ground has been prepared, that is, only where there has been some arrest in the ego's growth. To state it another way: transitional object relations are a necessary but not a sufficient cause of schizophrenia.

I have placed special emphasis on the 'ability to suspend relations to objects', using as an analogy the normal state of sleep. This analogy is, however, inaccurate, at an important point. In sleep we do not find substitutes for relations to objects that have been suspended. In schizophrenia such substitutes are established. I have attempted to show elsewhere (Modell, 1958) that auditory hallucinations serve as substitutes for the 'real objects' that have been lost, although in a certain sense, as Rochlin (1961) has emphasized, objects are never entirely relinquished. It is of the utmost importance to know whether these objects are other human beings or are, in Schreber's terms, 'cursorily improvised'. The capacity to conjure up substitutes for other human beings is one which we do not all possess.

I will now attempt to gather up some of the loose strands of my argument. Psycho-analytic exploration of the borderline states suggests the hypothesis that they represent a syndrome separate from the major schizophrenias. The

essential difference rests in their lack of capacity to suspend or abandon relations to external objects. It is possible that this capacity is the result of a biological variation of the central nervous system and is not in itself psychologically determined. In their character development, individuals who develop the major schizophrenias share with the borderline group the fact that their object relations tend in the main to be arrested at the stage of the transitional object. Whether the pre-schizophrenic and borderline character disorders can be further distinguished from each other is a question that we are not prepared to answer now. This hypothesis suggests at least two different orders of possible biological determinants in schizophrenia: the one has to do with an impaired capacity to develop mature object relations and is presumably operative from birth onwards; the other concerns the capacity to suspend relations with objects, and this particular anomaly could become manifest at varying ages in the life of an individual, in some instances not until full maturity or middle age. The arrest of ego development at the level of transitional objects is a necessary but not sufficient determinant for the development of a major schizophrenia.

If our nosological criteria are based on the capacity to suspend object relations and enter a dreamlike state, it can be seen that the concepts of reactive and process schizophrenia need to be re-evaluated. Our hypothesis suggests that the distinction between psychological and biological factors in the development of schizophrenia has little to do with the outcome or prognosis. For example, it has been customary to follow Kraepelin (1919) in the belief that the more severe and deteriorating disorders are organic in origin, while the transient schizophrenias are psychogenic or reactive. This mode of thinking receives no support from medicine, where an acknowledged organic disorder may run the gamut from mild and transient to severe and debilitating without leading one to assume differing etiologies. I see, therefore, no reason to link chronicity with the biologic, and transient states with the psychogenic. Although we can

discern that an individual may enter a transient schizophrenic turmoil as a result of readily identifiable psychological traumata, we should not therefore assume that the schizophrenia itself is explainable on purely psychological grounds. Whether such a person recovers may also be observed to be again the outcome of psychological factors, e.g. whether the environment affords him any real satisfaction; this observation, however, should not lead us to conclude that the disorder is entirely psychogenic, for in medicine we know of many instances where recovery from organic illness is influenced by environmental factors. We can further note that psycho-analytic observation of character disorders provides no support for the notion that what is transient is psychogenic and what is stable or unchanging is of biological origin. For psycho-analysis is well acquainted with a variety of extremely rigid, relatively unmodifiable character disorders which do not necessitate, because of their poor prognosis, the introduction of a special biological hypothesis. There is no reason to connect prognosis with etiology. From this point of view the individual with a circumscribed paranoid character development who may have the poorest prognosis may have a more purely psychogenic disorder as compared with an acute but transient schizophrenic turmoil state. I believe that our hypothesis would explain the paradox that Jackson (1960) noted, namely, that the chronic paranoid who has nearly as bad a prognosis as the simplex patient shows the least variation from the norm in physiological terms, in weight and intactness of intelligence, dilapidation of habit patterns, etc.

It has been the theme of this paper that psychological knowledge has a certain priority over the biological, a priority in the sense of sequence of observation; that is, that the more inclusive, imprecise psychological observations must precede the less inconclusive, more precise biological observations. The psycho-analytic psychiatrist has first to sort things out in order that the biologist may know where to look. This hypothesis is one that is not proved, but is, I believe, quite testable.

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THE CONCEPT OF NARCISSISM IN SCHIZOPHRENIC STATES

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The concept of narcissism is fundamental to psycho-analytic theories which set out to explain the appearance of schizophrenic manifestations. Freud (1911, 1914) suggested that partial or complete libidinal withdrawal (decathexis of the object world and the corresponding mental representations) is followed by a libidinal regression to a narcissistic phase. This regression may be continued to a primitive (pathological) auto-erotic stage. He pointed out that the mixture of symptoms so frequently encountered (paranoid and hallucinatory experiences) was probably due to reactions (restitutional trends) to the narcissistic and auto-erotic regression.

The theory of narcissistic regression has proved of extreme value in enabling the clinician to relate a number of clinical phenomena which occur in almost every schizophrenic illness. The concept has thus had a unifying and integrating influence. Delusions of grandeur, magic thinking (omnipotence of thought), certain forms of auditory and visual hallucination, alterations in body awareness, withdrawal of the interest in the world and complete self-preoccupation can all be understood as the result of a regression to a narcissistic phase. Other data—e.g. delusions with persecutory content—can be regarded as reactions to this regression.

Some modification of Freud's original hypothesis has been necessary in the light of the changes which have taken place in the sphere of instinct theory. Today reference is made to the deneutralization of aggression and sexual drives which occurs simultaneously with the narcissistic regression. The instinctual cathexes fall under the sway of the primary process. Verbal ideas, imagery, memory traces receive these cathexes. They are no longer innervated by neutralized cathexes which are an integral aspect of the secondary process—of ego functioning.

The purpose of this paper is to enquire into the nature and function of the narcissism which characterizes schizophrenic manifestations. This

would seem to be a useful undertaking because of the fact that narcissism is a concept which is generally invoked to explain both normal mental functioning and the mental state of those who develop psychoneuroses and sexual perversions. In addition to this, narcissistic phases are regarded as developmental states in both infancy and early childhood. The question is, how do the different forms of narcissism relate to the narcissism of the psychotic patient? In what way does this narcissism differ, and what is its function?

Before attempting an elucidation of these differences it is important to recall that psycho-analytic investigations—particularly the work of Federn (1953)—indicate that the object relations of a schizophrenic patient during the illness and in the prepsychotic phase have a narcissistic basis. The cathexes which are directed to objects are not object-libidinal in nature but consist of narcissistic (instinctual) libido. Katan (1954) has also pointed out that a special narcissistic form of the Oedipus complex is to be observed in schizophrenic patients. In these individuals the mother embodies the boy's wished-for femininity. The patient does not invest the mother with object libido but instead the object cathexis is based upon the perception of his own femininity. Nunberg (1955) has similarly drawn attention to the association which exists between 'loose' object relations and the tendency to project aspects of the self (narcissistic cathexes) on to the object.

It is generally assumed that these narcissistic object relationships in the schizophrenic or pre-schizophrenic patient reflect narcissistic fixations which have occurred during the development of the instinctual life. Such considerations raise further important issues because narcissistic forms of object relationship are not confined to schizophrenic patients. They occur also in healthy individuals, in psychoneurotic patients, and particularly in the sexual deviations. It may be instructive therefore to begin this inquiry by

some reference to the narcissistic phenomena which occur in non-psychotic cases. By doing so, some insight may be gained, first, into the factors which promote pathological narcissism and, second, into how far these considerations are relevant to the narcissism of the psychotic patient.

Narcissism in Sexual Deviations

The psycho-analytic treatment of sexual deviations has thrown light upon the origins of narcissistic object choice. This knowledge has come from the form transferences take in these cases and from accounts of childhood experience. In the vast majority of such cases the growing capacity for object relationships is disturbed by traumata of various kinds. Two illustrative examples are described below. In the first case the patient had been looked after in childhood by a series of nursemaids while his mother continued with her profession. A consequence of this was enuresis and faecal soiling (encopresis). At 4 years of age the patient was evacuated to the country, where he was in the care of a woman who terrorized him. In a second case, the patient had a very close and intense relationship with his mother until the age of 4 when a brother was born. Until his brother's birth he had slept in his mother's bed. She was in the habit of exciting him excessively by fondling his body, biting him playfully and caressing his buttocks. This concentration of attention was heightened by the mother's disappointment in the father who became bankrupt when the patient was about 3 years old.

When patients who are dominated by narcissism in their object relations enter psycho-analytic treatment the transference immediately falls under this influence. The patient considers himself completely superior to the analyst, and this can be a source of serious resistance, as Abraham (1919) pointed out many years ago. Occasionally this grandiosity is hidden behind a façade of timidity, and it is expressed in a delight in finding fault with the analyst, and exposing his mistakes when they occur. In other instances the patient endows the analyst with omnipotence and omniscience. Anna Freud (1954) has referred to the difficulties which these patients present. In such cases the patient is easily disappointed and refuses to acknowledge or tolerate the limitations of the analyst or the treatment. If the analysis is able to advance, the grandiosity and conceit is soon found to be based on anxiety.

As these analyses proceed, the fluidity of the patient-object (analyst) duality becomes apparent. This fluidity characterizes every relationship which the patient has entered since early childhood. In the course of one or two sessions the patient may switch roles with the analyst on many occasions. In the second case referred to above, the patient grumbled and complained about the analyst's performance in just the same way as he had done with his mother. At a later point he feared mutilation, being poisoned, devoured, or being controlled magically by the analyst, once again in the role of the mother. At other times he revealed an identification with the mother and behaved towards the analyst as if the latter were himself.

In this case the slightest sign of withdrawal of interest on the analyst's part—for example, change of time, slight delay, meeting another patient by chance—led to an intensification or to the reappearance of homosexual inclinations and to resistance in the analysis. This resistance took the form of an aggressive silence. It was punctuated by veiled criticisms and by the following behaviour: he would begin to relate some incident pertaining to the analysis and then forget what he had wanted to say. On one of these occasions he prefaced this forgetting by saying that a friend had been about to confide in him and then changed his mind. The patient identified with the frustrating friend. He thus reversed roles with the analyst and disappointed him as he felt himself to be disappointed by his friend in the present and by his mother in the past. He deprived the analyst of material as his mother had once deprived him of love and attention. The analysis of the introjective defences resulted in this patient's becoming aware of his own oral and anal sadistic transference phantasies which had followed upon frustration and disappointment.

In the first case (the patient who suffered from enuresis and encopresis), terror of the analyst repeated the dread of the numerous 'mothers' which he had had in childhood. This man regarded the analysis as a kind of forcible exposure of his body—again a repetition of actual events in childhood. Once exposed something would be taken from him against his will. He likened this to circumcision and to the enemas which were so frequently administered in his early years. These assaults upon his body and the constant feeling of helplessness were countered by omnipotent (narcissistic) phantasies in which he controlled and punished at will. These

masturbatory phantasies could be traced back to childhood, when erections induced at will gave him feelings of power and strength. The penis was personified as an object at the mercy of his commands. In this example the close association between auto-erotism and narcissism is clear to see.

In this patient, as in many others, self-love replaced object-love and served as a defence against further mental pain. This self-love (pathological narcissism) is compounded of introjective and identification processes. Through internalization the patient seeks to recreate a wished-for love relationship which may once have existed and simultaneously to annul the anxiety and guilt aroused by aggressive drives directed against the frustrating and disappointing object. These processes are re-experienced in the transference relationship, as has been described above.

It would appear therefore that narcissistic fixations—attempts to annul the pain of disappointed love—will occur when individuals are subjected in early childhood to injury to their developing object libidinal capacities. These traumata lead to introjective processes and thus to identification with the disappointing object. Auto-erotism and its accompanying mental representations is utilized to help overcome these traumata, and this enhances the narcissistic disposition. Identification itself, as Freud pointed out, involves the transformation of object libido into narcissistic libido. When disappointments occur in adult life regression to these narcissistic fixation points rapidly takes place; object cathexes are replaced by identifications. This is commonly the situation at the onset of the homosexual perversion. The heterosexual object (generally chosen on a narcissistic basis) is lost, and is replaced by a homosexual relationship.

Narcissism in Schizophrenia

Illustrative Case
Chance provided an opportunity to study a schizophrenic illness in the prepsychotic phase and during the psychosis proper. The patient, a single woman of 28, was referred to an outpatient clinic complaining of depression of mood, irritability and fatigue. She was self-reproachful, but free of suicidal ideas. There was nothing to suggest a psychotic depression, far less a schizophrenic illness.

The illness was not new and the history

went back to the age of 26. She was admitted to hospital at that time because of erratic and unpredictable behaviour. Her general practitioner feared that she might be suffering from a schizophrenic illness. According to the patient's statement at that time, difficulties first appeared when she began her University career. Before this she was considered good-natured and conscientious. Her school record was excellent. During the first year at University she failed some examinations, and this led to low spirits and unhappiness. In the following year she fell in love with a lecturer at the University, and disappointment in this regard was accompanied by a general deterioration in her performance. She began to miss classes, was difficult at home, and failed her examinations.

During this last period relations between mother and daughter deteriorated. When she failed to get her degree at the end of the second year—she graduated subsequently—she went to London and worked there for six months in different jobs. When she returned, everyone noted how odd her behaviour was. She was alternately elated and dejected. Within a few weeks a depressive tendency became manifest. She was tearful, self-critical, and agitated. She refused to come out of her room, and her personal habits deteriorated. She tried once more to go to London but returned within a week. After the passage of a month or two she agreed to undertake a teacher training course. Unfortunately she met the same lecturer—a married man—with whom she had been infatuated previously, and this led to a worsening of her mental state. She refused to get up in the morning, and would constantly criticize herself, saying 'I am no good'. This state lasted for a number of months. When she was a little better she obtained a job which she held for one year.

Gradually she became moody and reverted to her depressed state of the previous year. She obtained another post, but was dismissed. This led to a new outbreak of symptoms and to referral to a hospital at the age of 26. On admission she was found to be co-operative and the patient was found to be co-operative and easy to make contact with. Her capacity to communicate was unimpaired. She was preoccupied with thoughts of the lecturer she had been in love with and her inability to succeed as a teacher. She said that she now realized that if anything was wrong it was her fault.

There was no evidence of a formal thought disorder, delusions or hallucinations. She admitted to acting on impulse. Her depressive symptoms disappeared within a matter of weeks, and she was discharged from hospital. During the following year she undertook a teacher training course and began work. After teaching for one year she noticed that she was for ever in low spirits, had lost confidence in herself, and had little interest in work. It was on this account that she consulted her doctor who referred her for a psychiatric opinion. The patient was offered psychotherapy on a psycho-analytic basis. At this time there seemed no reason to suspect that this woman was potentially psychotic. The out-patient treatment continued for a period of four years until she had to be re-admitted to a mental hospital at the age of 32.

The psychotherapeutic process can, for the purposes of description, be divided into three phases. The initial phase was characterized symptomatologically by depressive manifestations. The patient was depressed in mood and self-reproachful. The self-reproaches were initially confined to her performance at work but later they found expression in other spheres—particularly in the patient/therapist situation. During this phase this woman developed an intense positive transference, and without much difficulty she expressed her love and desire for the therapist. Her idealization stamped this transference as narcissistic. She believed he had abilities and attributes quite beyond his real capacities, and refused to examine the background of such beliefs.

It was not long before she began to express concern for the therapist's health and welfare. The self-reproaches, which had previously been confined to the work situation, now extended to the therapist. She was for ever worrying in case she had upset him. She inspected his appearance whenever possible to ensure that he looked well. She worried lest her case imposed too great a strain and made him ill. Throughout this time she did everything which she thought would please the therapist. She tried to make the ideals and standards which she attributed to him her ideals.

During the early part of this phase she talked about her family circumstances. Her father was unequal to his temperamental wife. The latter was an unstable, irritable, and quarrelsome woman who liked to have her own way. The patient was the eldest of five

daughters. The next sister was born when the patient was 5 years old—the others when she was 7, 9, and 13 years old respectively. When the patient was 2½ years old she was admitted to hospital on account of eczema and remained there for three to four weeks. During this stay in hospital her limbs were splinted to stop her scratching.

She had no difficulty in expressing her dislike of her mother and her conviction that the latter had never had any interest in her. The acceptance of death wishes towards the mother and sister led to some alleviation of guilt and of the depression. Her work at school improved and she seemed much more settled. There was no change, however, in the narcissistic nature of the transference. The therapist was still idealized. Much attention was paid to the analysis of introjective defences, without any appreciable result. The patient had securely internalized both the therapist and the sadistic phantasies which were directed against him. The mother was bad, the therapist good. This isolation mechanism continued throughout the whole of the first phase. Projection of superego attitudes—exacerbated by the introjection of aggression—onto the therapist led to a fear of being criticized and found wanting.

Holiday periods were difficult for the patient. She was generally depressed and worried about the therapist. While she was willing to phantasy about the therapist's holiday activities she was unable to express any dissatisfaction at being left. Towards the end of the first phase, which lasted for nearly the whole four years, she brought confirmation of the narcissistic phantasies which her behaviour and utterances had suggested. These came to light during a recurrence of depressive symptoms. She explained that for a long time she had been convinced that the improvement in her mental state and her life situation was due to actual interventions by the therapist. She had thought that he had spoken to the headmaster of her school on her behalf and made arrangements for her to find comfortable lodgings. At this time, however she generally realized that this could not be true and must be imagination.

Although little progress was made in dissipating the resistance of idealization (narcissistic transference), a great deal of material was obtained relating to her early childhood and to the traumata of hospitaliza-

tion and the birth of her sister. The separation difficulties which appeared in the transference situation were a repetition of these early experiences. The introjective defences so clearly seen in the transference suggested that these were the mechanisms utilized in childhood to deal with the hate engendered by loss. The patient's identification with the therapist was a new version of the identification with the mother. At no time was this patient ever able to accept, other than intellectually, the hatred which she bore against her mother.

The second phase of the therapy lasted only a few weeks. At first there was no special indication that the patient had altered. She was inclined to be silent and withdrawn. This was inclined to be silent and withdrawn. This behaviour did not give cause for anxiety because it had appeared many times before. Gradually, however, she became depressed in mood, and there was a return of other depressive manifestations. This development was unexpected, because things seemed to be going well. She had started going out with a man some months earlier and was happy about this. Only later did she announce that this relationship had come to nothing and it was this disappointment which ushered in the second phase. As might have been expected, this man was chosen on the basis of narcissism. She over-valued intellect, and her man-friend was highly intelligent and cultured. This choice was no doubt determined by transference, but in such a patient such a development suggested a widening of her activities.

Investigation of the depressive outbreak showed that its onset coincided with a disagreement with her landlady. She expressed much resentment against this woman; but no real cause could be found for this attitude; it was utterly inappropriate. Her behaviour suggested that an aggravation of the mother relationship was already active. Shortly afterwards she became very upset, saying that the therapist was angry with her and that the landlady's behaviour was a message from him announcing his displeasure.

In the next session it became obvious that for some weeks the patient had been experiencing auditory hallucinations, in which the therapist's voice talked to her. Usually what was said was pleasant and reassuring. The voices indicated the closeness of the therapist. She believed that she had noticed the therapist walk past her window and she

was sure she had seen him at school. Associated with these ideas was a confused feeling, of being all 'mixed up', no longer an independent entity, and of being unable to oppose the thoughts of those with whom she came in contact.

The transition from the second to the third phase occurred whenever the patient began to develop persecutory ideas. She accused the therapist of arranging for the landlady to annoy and upset her. The landlady was putting the patient's underclothes near the window to embarrass her. She was leaving dishes unwashed and playing the piano to annoy her; nothing happened in the house which was without significance. All such occurrences were the result of the therapist's activities. Coincidental with these persecutory ideas she believed that it had all happened because she had annoyed and irritated the therapist. She seemed calmed and reassured by the ventilation of these thoughts. It was about this time that she revealed that she was no longer meeting her man friend.

During the next two months she seemed to be making progress towards gaining insight into the irrational nature of her ideas. She acknowledged the guilt which had been generated by sexual interest in her man friend, and at the same time seemed to be aware of the anger occasioned by her rejection. However, this favourable trend came to an end with the sudden appearance of a full-blown delusional complex. In a state of great distress she said that the night before she was forced to have sexual relations with the therapist—she felt his body beside her. There were microphones and some kind of television machine which transmitted everything that was going on. When she experienced sexual feelings the therapist had sexual feelings. She felt herself to be a part of him. She explained that the persecution had been initiated by the therapist's wife, and that the latter had obtained the help of her friends to injure and damage both the patient and the therapist. They had made her think that she could have sexual relations with the therapist in order to incriminate her. They were determined to punish her, and she interpreted every environmental experience as related to this persecution. She believed that the therapist was upset, and when she wept she knew that he was weeping also.

The patient was admitted to hospital on the

day of these disclosures. Persecutory delusions and auditory hallucinations continued for a number of months later to be accompanied by the appearance of depressive symptoms, and a fear for the therapist's future.

Discussion of Case

In the prepsychotic phase the patient made narcissistic object choices in much the same way as do patients with sexual deviations and character defects. The analytic work undertaken in the first phase showed that this narcissism had arisen primarily as a defence to counter psychic pain following childhood traumata. The narcissism was in part the result of introjections which affected both object and instinctual drive. The transference manifestations revealed these processes clearly, and the predisposition to depressive attacks arose upon the basis of these introjective mechanisms. Depressive attacks are also particularly common in cases of sexual deviation whenever there is a threat to the integrity of the deviation itself. This is a logical outcome of the introjective mechanisms which are always present in such cases. In the case described, guilt regarding auto-erotic practices deprived the patient of a means of dispelling the depressive affect. She was unable to sexualize the traumatic experiences, as in cases of perversion.

It was only at the beginning of the second phase that the dramatic change in the nature of the patient's narcissism took place, rendering it quite unlike that encountered in the sexual deviations. Although the patient had moments of insight into her ideas she usually had complete conviction in her beliefs. She was withdrawn from the world of reality and completely preoccupied with thoughts of the therapist. In metapsychological terms, the regression had affected the instinctual basis of object relations in such a way as to lead to a withdrawal of cathexes (narcissistic) from objects and their being invested in thought complexes (phantasies) and memory traces. Wishes came true—the therapist was with her, looking after her, and she could hear his voice. Guilt led to a fear of the landlady and to the fear that she had displeased the therapist. This oedipal colouring of the manifest material is a common feature in schizophrenic states.

An important aspect of the second phase lay in the fact that although the patient's narcissism had become more extensive and pathological she had not completely abandoned her relation-

ship with the object (the therapist). In this respect the clinical data were characteristic of phase one of Freud's model of psychosis—withdrawal (complete or partial) of object cathexes and the regression to narcissism.

The appearance of the third phase was characterized by further changes which can be explained as resulting from both narcissistic and ego regression; it may be that the impact of the former was more than the ego could assimilate. The material showed, first, that the patient was unable clearly to discriminate herself from the therapist—a state akin to that conceptualized as primary identification—and second, that she now used the projection mechanism freely. Others made her have sexual feelings; they were about to destroy her and the therapist. At no time, however, was her sense of identity, in contrast to her discriminatory capacity (self-object), ever in jeopardy. In the third phase, the exteriorization of the superego—itsself a product of introjection and projection processes—indicated the degree to which dissolution of psychic processes had occurred. This was matched by the exteriorization (projection) of id impulses.

It would appear that the precipitation of the psychotic phase was activated by the loss of the male friend. This relationship had presumably awakened genital drives which the patient was unable to assimilate. In this respect the material of the first phase showed that she had conducted a continuous, unconscious struggle against masturbation and the derivatives of the phantasies in the transference. There was some indication of a short-lived, intense childhood masturbatory phase which had succumbed to repression. Masturbation with oedipal phantasies burst into consciousness in phase three and it was these phantasies which assumed delusional quality as the result of the regression to narcissism.

It is reasonable to assume that the main source of dread in phase one was oedipal wishes—the narcissistic Oedipus complex to which Katan (1954) refers. The therapist embodied the patient's wished-for masculinity. This dread demanded that she should remain tied to the mother relationship and not proceed beyond it. Once this defence failed—overwhelmed by the stimulation and disappointment of an actual relationship—regression ensued. In the last resort the decisive factor was economic. Sexual and aggressive wishes—the instinctual cathexes—resulted in cathectic withdrawal and narcissistic regression.

The Nature of Narcissism in the Schizophrenias

Psycho-analytic investigation of sexual deviations and schizophrenic states demonstrates unequivocally that two major categories of pathological narcissism can be distinguished. Reconstruction of prepsychotic phases and information gained during the schizophrenic illness itself suggests that the differentiation between these two forms of narcissism occurs only when the psychosis makes itself manifest. Until this time object relationships are similarly based—that is, upon narcissistic cathexes. Examination of the life history also indicates that in both groups of patients the instinctual life has been arrested in its object-cathectic aspects by narcissistic fixations. These fixations result, as Freud (1914) originally demonstrated, in the image of the self being taken as the model for object choice.

During the analytic therapy of the sexual deviations the constituent processes which led to the pathological narcissism are laid bare. It is generally recognized that processes of internalization affecting both object and instinctual drive predispose towards this result. Introjective mechanisms employed to deal with anxiety generated by aggression attendant upon loss and disappointment prevent the development of object-libidinal cathexes. The transference situation allows the emergence of these internalized object relationships, and their characteristic fluidity has been described. In spite of this, deviant patients never fail to discriminate themselves as entities.

The pathological narcissism encountered in the sexual deviations has a defensive function, and it is for this reason that it manifests itself as a resistance in the transference. It is essentially a *secondary phenomenon—a reaction to anxiety and guilt. It is this form of narcissism which provides the best data for the illustration of the processes involved in the developmental phase described as secondary narcissism.* The latter, as in the pathological model, arises on the basis of a withdrawal of object libidinal cathexes which are then internalized (introjected) into the ego along with the object of the drives. This internalization leads to ego identifications (secondary identification).

The form which the pathological narcissism assumes in the schizophrenias is so strikingly different that there is every reason to believe that its nature is different also. Examination of schizophrenic states shows that along with the

appearance of the pathological narcissism there occur certain manifestations which can only be ascribed to the activity of the primary process. The latter governs the content of delusions and it is instrumental in leading to auditory and visual hallucinations. The varying degrees of failure of self-object discrimination and the disorder of conceptual thinking must be attributed to the primary process.

Delusions with grandiose content are the most obvious expression of the pathological narcissism. These delusional formations are usually regarded as having a defensive function. In this respect, therefore, the narcissism appears to have the same function as it performs in the perversions. As a rule these delusions are in the nature of a reversal of the patient's true situations. The content enables the patient to deny his real state and to substitute in its place something more agreeable and pleasing to self-esteem. This aspect of delusional ideas can be likened to the form of childhood thinking which Anna Freud (1937) has described as 'denial in phantasy'. She says '... the method by which objective "pain" and objective anxiety are avoided is very simple. The child's ego refuses to become aware of some disagreeable reality. First of all it turns its back on it, denies it, and in imagination reverses the unwelcome facts ... if the transformation is successful, and through the phantasies which the child constructs he becomes insensible of the reality in question, the ego is saved anxiety and has no need to resort to defensive measures against its instinctual impulses and to the formation of neurosis.' Persecutory delusions can similarly be regarded as the result of the pathological narcissism and as having a defensive function.

It is now appropriate to consider whether the defensive function which paranoid delusions (based on narcissism) undertake is identical with the narcissistic manifestations which occur in the sexual deviations and in character abnormalities. The view taken here is that in the former there is no question of complex psychic content as in the case of the latter. The pathological narcissism which finds expression in paranoid delusions is not compounded of internalized object relationships but is a pathological variant of the functional state designated as primary narcissism.

Theories of narcissistic defence had led to doubts about the concept of primary narcissism, and indeed, if this conception was merely an intellectual artifact, then it would be meaningless

to describe the pathological narcissism of the schizophrenias as a pathological variant of primary narcissism. It is in the very nature of narcissistic organizations whether normal or pathological that the object world becomes subject to the individual's wishes and phantasies—word representations take the place of object representations. The question is, what is the origin of this narcissistic disposition? An answer to this question is provided by Freud's (1914) statement that narcissism is not a primary state of the mental apparatus. Freud proposed (1914) that '... there must be something added to auto-erotism—a new psychical action—in order to bring about narcissism'. As Bing, McLaughlin and Marburg (1959) point out, the answer to this question is given by Freud (1914) a line or two earlier when he says '... the ego has to develop'. The beginnings of narcissism must be dependent upon a sense of self, however fragmentary and unstable.

According to this way of thinking it is the auto-erotic drives of infancy which provide the basis for narcissistic organizations. It is through the auto-erotic zones that the child can obtain pleasurable sensations. They can be obtained at will, and in these early times are independent of an object. A belief in the power of wishes supervenes, and this contributes to the foundation of narcissism.

In one of the non-psychotic patients described above, auto-erotism was utilized in childhood to produce the narcissistic phantasy of omnipotence. Narcissism thus receives its power from auto-erotism. It is only with the appearance of object-libidinal cathexes and the corresponding diminution of auto-erotism that narcissism becomes limited in expression. The loss of object cathexes heightens auto-erotism and leads to a potential increase in narcissism. This is easily discernible in the healthy as well as in the psychoneurotic subject. Wishful phantasies and self-preoccupation replace the lost object relationship. Their conscious representation will depend principally upon superego attitudes. In psychotic patients the complete breakdown of repression can lead to a vivid expression of this auto-erotism which can either be oral, anal, or phallic. The auto-erotism of the schizophrenic patient discussed above appeared in the delusional ideas about intercourse with the therapist. Concomitant with the development were the other manifestations of psychotic narcissism.

Roheim's observations (1955) on the origins of magic give support to the idea of a relation-

ship between auto-erotism and narcissism. Magic thinking is a counterphobic mechanism enabling the individual to free himself from dependency and the threat of object loss. In this respect magic is defensive in the same way as are the grandiose delusions and omnipotence of the psychotic patient. Roheim goes on to point out that magic is based upon the child's capacity to call 'on the sources of pleasure within its own body'—that is, upon auto-erotism. 'Magic may thus be oral, anal, urethral, narcissistic or phallic. It is our great reservoir of strength against frustration and defeat and against the superego. While the magical omnipotence phantasy of the child means growing up, magic in the hands of an adult means a regression to an infantile phantasy' (Roheim, 1955).

A further source of narcissism is to be found in the hypothesis of hallucinatory wish fulfilment—based upon the data of dreams and clinical observations. Freud (1900) proposed that the first mode of cognition results from the frustration of drives. The reaction consists of the revival of memory traces of past satisfactions which are then transformed into perceptions (hallucinatory experience). Drives are intimately linked with these memory traces and thus wishes—the mental representation of the drives—can achieve a transient reality in infancy and early childhood. This mechanism remains intact in later years although buried beneath the processes which are concerned with environmental adaptation—with the reality principle and the secondary process. According to Freud's hypothesis (1900) the cathexes underlying the wish are detached from the object (the breast) and then utilized to energize memory traces bringing them to a hallucinatory condition (topographical regression). Roheim's (1955) explanation of magic is based upon the same principle. Cathexes are withdrawn from objects and invested in verbal ideas.

The pathological narcissism of the sexual deviant does not involve the activation of the primary process in such a way as to lead to perceptual and conceptual discriminatory failure. Primary processes operate under the dominance of the ego; thus phantasies never attain the reality quality which is characteristic of delusions. In these cases the ego remains intact and the pathological narcissism—defensive in aim—is a deviant form of secondary narcissism. In the schizophrenias the instinctual regression leads to a pathological narcissism in which the sense of

self may be retained but the patient does not always clearly discriminate himself from others in his environment. Further regressive movement beyond this narcissistic stage can lead to a loss of identity and to a general fragmentation of mental function.

It is the uncontrolled activity of the primary process in schizophrenic states that leads to the formation of ideational complexes—delusions, hallucinations—in which the patient has complete belief. These complexes are utilized reconstitutionally, to use Freud's (1911) expression. The conflicts regarding real object relationships have by this time assumed a secondary significance because they had been abandoned at the onset of the illness. This applies to both external objects and to their endopsychic representations. In a previous paper (Freeman, 1962) an attempt was made to demonstrate that reconstitutive phenomena should not be regarded primarily as defences against emerging repressed contents. Their structure is quite different from the psychoneurotic symptom, which is a compromise formation between repressing forces and the repressed. According to Glover (1949) 'The psychotic cannot stem the repression by producing compromise products; repression failing, his regression stops only when he can live at an archaic level free from superego pressure and able to discharge id tension more freely than the psychoneurotic and *a fortiori* the normal person is able to do. The symptom formation is therefore a reactivation of archaic functions, through which conflict elements are almost totally denied.' Delusions and hallucinations are principally concerned with protecting the residual ego from further deterioration. The loss of these psychic formations exposes the vulnerable mental organization to the anxiety which was attendant upon the initial withdrawal and regression of object cathexes. It is only with the resolution of the regression which affects the instinctual basis of object relations and with the recathexis of the object world that the need for reconstitutive phenomena becomes unnecessary.

The concept of primary narcissism embraces the idea of a primitive self which is not differentiated from objects: it does not mean that there is no relationship with the object world. During this phase the mental apparatus is governed by the primary process; cathexes are instinctual and mobile. It is the phase of hallucinatory wish fulfilment. Primary narcissism provides the principal reservoir of cathexes for the phantasy thinking which occurs in healthy individuals

throughout life. In the schizophrenic patient a state is reached which has all the characteristics attributed to primary narcissism.

The purpose of this paper has been to demonstrate that in schizophrenic states a pathological narcissism appears which is completely different in nature from that encountered in the sexual deviations, in character abnormalities and in the neuroses. In the former the narcissism can be regarded as a pathological variant of primary narcissism, and thus closely related to it. In the latter the narcissism assumes a form based upon secondary narcissism. Similarities within the two groups exist only while the schizophrenic patient is in the prepsychotic phase, as was demonstrated in the case described above. While in this state the patient's narcissism is based upon secondary narcissistic processes, and is thus similar to cases of perversion. At the same time this narcissism is compounded of introjective processes, and acts as a defence against anxiety and guilt springing from object relationship conflicts which have been internalized.

Once the schizophrenic illness breaks out, the narcissism upon which the delusions and hallucinations are based is no longer related to the prepsychotic narcissistic manifestations. They belong with the 'non-psychotic layer', to use Katan's (1954) term. The prepsychotic narcissism, like the narcissism of the sexually deviant, operates under the influence of the secondary process. It is subject to a series of controls which prevents the emergence of the narcissism which is characteristic of psychosis. This non-psychotic narcissism is confined to self and object representations; it is in this respect discrete and differentiated. Schizophrenic narcissism is diffuse and not limited to self and object representations because of the dominance of the primary process. Mental functioning in these circumstances can again be likened to the phase of primary narcissism because in this hypothesized developmental phase mental activity is not governed by anxiety or guilt emanating from ego or superego structures. Mental function is under the rule of the pleasure principle. This is the state of the mental apparatus which Glover (1950) has referred to as the 'primary functional phase'.

The mental state of seriously deteriorated patients indicates that the disease process leads to a pre-structural state where the ego is fragmentary and the superego non-existent. In one instance a patient passed from a condition in which the ego and superego had partial function

to a state in which they were virtually without representation. The patient was a man of 46, who had been hospitalized for many years. During certain phases of the illness he was depressed in mood and self-critical. He had delusions in which he accused himself of various crimes, and had auditory hallucinations with a similar content. He also believed that his wife was intending to kill him. His cognition in this state was fair. He could use words reasonably well, but his perceptual function was deficient in so far as he misidentified people and had difficulty in discriminating himself from others. He did not have any difficulty with respect to his sense of identity.

During psycho-analytic investigation he showed that he was concerned for the welfare of the analyst and that aggressive drives were introjected into the superego as a defence. It was, however, of special interest that he could not successfully introject the object which he felt he might have damaged. This failure could be attributed to the deficiency in the ego boundary. Exacerbations of anxiety about his health or his future were always paralleled by similar anxieties about the analyst. This contrasts with successful introjective defence when anxiety about the object is completely relieved and replaced by self-concern. The supremacy of the primary process explains this inability to differentiate self-object representations—again a characteristic of the primary narcissistic state.

This depressed state alternated, at varying periods of time, with over-activity and with an even greater cognitive disorganization. Verbal communication was extremely difficult and perceptual discrimination seriously damaged. In this state the patient was careless with himself, exposing his genitals, masturbating, and dirty in the extreme. The delusional content was now entirely grandiose. In the investigation (patient-analyst) situation, both aggressive and sexual drives had free play. He was critical, aggressive, and at the same time demonstrated exhibitionistic and homosexual tendencies. This material suggests that the ego was seriously damaged in its cognitive as well as its defensive functions—the superego which previously had been partially externalized was now completely out of commission. Delusions of grandeur (psychotic narcissism) had full expression undisturbed by superego pressure. Damage to the counter-cathexes allowed the expression of instinctual drives.

In this condition mental life has almost returned to its original undifferentiated state,

although ideational representations might give the impression of higher-level activity. Changes in the level of instinctual tension, in turn dependent upon the degree of inner stimulation and capacity for instinctual release, determined the nature and form of the clinical phenomena.

Psychotic narcissism can therefore be looked upon as a manifestation of an endopsychic interaction between processes of 'excitation and discharge' (Glover, 1950). The dissolution of ego, superego, and the secondary processes allows this state to supervene. The pathological narcissism of the schizophrenic is not the outcome of defensive processes arising out of disturbed object relationships as is the case with the narcissism of the sexual deviations. It results from the activity of the primary process which 'constructs' the delusional ideas and the hallucinatory phenomena. The content of these 'structures' is derived from prepsychotic conflicts which still find expression in the 'non-psychotic layer'. The delusions and other pathological products will assist in the trend towards creating an equilibrium between processes of excitation and discharge.

Examination of the clinical data suggests that in the individual schizophrenic patient narcissistic manifestations can be divided into separate categories. First place must be given to the psychotic narcissism which characterizes the schizophrenic process. This narcissism may be conceived as a functional state in so far as it expresses the economic situation existing within the pathologically disordered mental apparatus. The phenomena through which it finds representation (delusions, hallucinations, etc.) are not directly related to conflict. They are not compromise formations, as are the symptoms of a psychoneurosis. Such constructions (compromise formations) are to be found in schizophrenic patients, but they are limited to the 'non-psychotic' layer.

The schizophrenic patient also demonstrates a non-psychotic narcissism which makes its appearance in the pre-psychotic phase as well as during the established illness. The composition of this narcissism is similar to that encountered in the sexual deviations and in the character abnormalities. In the schizophrenic patient this narcissism is not part of the psychotic process, but belongs with the 'non-psychotic' layer. It is the failure to differentiate between the two forms of narcissism in any one case of schizophrenia which has led to the theory that narcissism in such cases is essentially a secondary (defensive) reaction.

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HOPE AND REPUDIATION OF HOPE IN PSYCHO-ANALYTIC THERAPY¹

By

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I.

In one of his technical papers, Freud (1912) tells of a therapeutic experiment. He told a patient (a young woman) about a repressed homosexual experience of which the girl's mother had informed him. The patient went into a convulsion each time Freud mentioned this incident. She finally 'simulated imbecility and total loss of memory' to defend herself against what Freud had told her.

This experiment illustrates a fact that we all know but sometimes forget about psycho-analytic therapy. We know that the deep unconscious is not directly accessible to therapeutic influence. The direct impact of the therapy is at the level of the system preconscious. We influence the unconscious only indirectly and very slowly through the medium of its preconscious derivatives.

In the course of a psycho-analytic treatment, patterns from the past are repeated over and over again. When our attention is focused on the past, nothing seems to change. What changes from week to week is much closer to the surface. Consequently, if we wish to understand the therapeutic process, we must follow very strictly Freud's advice to 'analyse from the surface downwards'. We must focus our attention first on what is happening in the system preconscious.

II.

Traditionally, when we analyse the patient's orientation towards present reality, we concentrate our interest chiefly on his resistances. Sometimes we take his therapeutic incentive for granted. We may even lose sight of the motives that keep him coming to the treatment in spite of his resistances.

This leads us to our most important thesis in this paper. This is that the therapeutic incentive which makes successful therapy possible must have its basis in the patient's latent and successively emerging hopes of finding a solution for his conflicts. This thesis is based on a more general one—that hopes play a centrally important part in the motivation and integration of all rational behaviour. They are the central core of the ego's integrative function.

Psycho-analytic literature, until recently, has given very little recognition to the significance of hope in human and animal behaviour. It is rather to poets and philosophers that we must turn for evaluations of hope and of its influence on behaviour. In general psychological literature probably the first to pay systematic attention to hope was Alexander F. Shand. In a book entitled *The Foundations of Character* (1914), Shand collected and tried to organize into a comprehensive system what literary men and anecdotal observers of animal behaviour had written about the part played by different emotions in the formation of character. He devoted a number of pages to hope, which he includes among the emotions subsidiary to desire. 'Hope increases the activity of desire', he writes, 'aids it in resisting misfortune and the influence of its depressing emotions, and in both ways furthers the attainment of its end.' He quotes a number of poets and essayists in praise of hope. Of these, a quotation from Amiel's *Journal intime* is particularly explicit and dramatic. 'At bottom', says Amiel, 'everything depends on the presence or absence of one single element in the soul—hope. All the activities of man presuppose a hope in him of attaining an end. Once kill this hope and his movements become senseless, spasmodic, and convulsive,

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like those of someone falling from a height.'

In a paper entitled 'Adaptation to Reality in Early Infancy', Benedek (1938) emphasized the importance, for the development of the infant's ego, of his 'confidence' in relation to his mother in earliest infancy.

In *Childhood and Society* (1950), Erikson sketched an outline of the psychosocial 'crises' that furnish the emotional background for the development of the ego from infancy to maturity. This development, he postulated, starts with the infant's 'basic trust' in his mother.

In a recent essay, Erikson (1962) has included hope as the earliest of the 'virtues' which guide the ego in its development towards integration within itself, with the mother, and then into the life of the family and the community.

In scientific literature on the motivation of behaviour, one reason for the relative neglect of hope has been failure to distinguish between hopes and other kinds of wishes. In two earlier papers (1941, 1945) and then in a series of volumes entitled *The Integration of Behavior*, French has made this distinction a starting point. He distinguishes between two kinds of wishes, two kinds of goals or poles of behaviour—between what one is trying to get away from or get rid of and what one is seeking. We try to get away from pain or from something that we fear, to put an end to hunger, to get rid of sexual tension. 'Need-pressure' is the name we give to such an urge to escape from or put an end to disturbing stimuli. We contrast such need-pressures with the positive attraction or pull exerted by *hopes*—which may be based either on present opportunities for satisfaction or on memories of previous satisfaction, or both.

Starting with this distinction, French elaborated the thesis that hope of success in carrying a plan through to execution is the essential dynamic source of the integrative capacity that makes it possible for the ego to subordinate effort to purpose in rational behaviour. Our thesis (above quoted) concerning hope as the essential basis for therapeutic incentive was elaborated and illustrated in detail in the third volume of this series.

More recently, Menninger (1962) has spoken and written in praise of hope. Starting with the pessimistic Greeks who condemned hope as an illusion and a curse, in contrast to St Paul who eulogized 'faith, hope, and love,' Menninger traces through history the strangely and intensely ambivalent feelings that have permeated the thoughts of philosophers, of religious teachers,

and of poets, about hope. He concludes by citing much general and clinical evidence in support of his conviction that hope is a potent and 'indispensable factor in psychiatric treatment and psychiatric education'.

The ambivalence of philosophers and poets towards hope is of considerable interest in relation to our present thesis. As the title of this paper suggests, our patients, too, give evidence of considerable conflict about entertaining hopes.

III.

Let us now repeat our thesis: The patient's therapeutic incentive is based always on specific hopes, which are in part realistic, of what the therapy can do for him.

We wish at the outset to forestall a possible misunderstanding. When we talk about hope we do not have in mind only some vague anticipation on the patient's part that the therapy will help him, or an equally vague confidence in the therapist, based probably on a rather unspecific positive transference. What we are talking about are specific hopes of exactly what the treatment can do for him. These hopes are usually only preconscious. They are always in part based on the realities of the therapeutic situation.

We must also warn against another possible misunderstanding. The hopes that we are speaking of are not the therapist's hopes for the patient. They are the patient's own hopes. They are not even hopes of which the patient is conscious. They are preconscious hopes which the patient must struggle energetically to repress and to repudiate. Indeed, repudiation of his therapeutically significant hopes is usually one of the patient's most important resistances.

To illustrate this thesis we shall now report parts of the analysis of a patient in whom this resistance against hope was unusually strong and persistent. This patient had been in analysis for some three hundred hours before we had begun our detailed co-operative study of her material. At this time and for many months before, the patient's hours on the couch had seemed to be characterized by a consistent, deadly monotony. Much of the time she was silent except when prodded by the analyst. Content, when it did emerge, was limited to seemingly natural and unavoidable reactions to the numerous petty irritations of everyday life. Interpretations seemed to elicit no response except on the most mundane and matter-of-fact level, completely devoid of fantasy or affect. The result was a profoundly bored and discouraged reaction on

the part of the analyst. He had lost much of his own hope of being able to help the patient.

This was the state of affairs when we became interested in reviewing this patient's case. Somewhat to our surprise, we then discovered that the patient's monotonous resistance had not been at all in evidence at the beginning of the treatment. It had developed at definite points in the analysis in reaction to specific dynamic situations.

In this paper we shall try to give the reader some picture of how our insight into the interplay of hope and disillusionment that constituted this patient's therapeutic process gradually deepened.

IV.

We will begin with an abbreviated summary of the patient's anamnesis, as reported in her first three hours.

The patient had come to analysis with a diagnosis of ulcerative colitis and had been accepted as a research patient. She had already had some psychotherapy from Dr E., a woman internist working in a university clinic. When first seen at the Institute she was 28 years old, rather frail and colourless in appearance, most subdued and shy in manner. She had been married for four years but was childless. She worked full-time in a clerical position. Her husband was employed as an engineer in an industrial plant and also attended night school, working for a college degree.

The patient was born in a small town in South Dakota, the third from the youngest in a Catholic family which included nine children. The true father was a rural mail carrier who was in disrepute with the rest of the family because he 'drank'. According to family accounts, the patient was his favourite child. He used to take her with him on his mail delivery rounds.

The mother had died only a day or two after the youngest sibling, a boy, was born. The patient herself was then about 4½. Thereupon a maternal aunt took the new baby, while the older children continued to live in the home, except for the patient and her next younger brother, Lewis. They were soon afterwards brought to Chicago to live with the father's sister and her husband, who became foster-parents. The patient and her brother were never legally adopted because the father would not give his consent. The foster-parents

nevertheless changed the children's surnames to conform to their own.

The patient could recall nothing of her real mother, or of anything antedating the mother's death. She did remember an older sibling's telling her that Lewis and she were lucky, that they were going to be able to go to Chicago to live. The patient was surprised. 'My grandmother later said that I was my father's favourite', she recalled, 'and she couldn't understand how he ever let me go.'

The patient stated that the major disappointment of her life occurred when she was 18, when she had to give up training as a nurse because of the acute and fulminating onset of her ulcerative colitis. After several weeks' hospitalization with high temperature and haemorrhage from the colon, she returned home to the family apartment for convalescence. Two years later her hopes of being allowed to re-enter training were finally denied by the nursing school authorities. Then, for once in her life, she allowed herself to weep. Being in training and living at the hospital had enabled her to associate with other girls and to be free of the restrictive demands of her foster-parents and grandparents at home.

Her position at home was in many respects that of a slavey. The foster-mother had no taste for home-making, and managed to keep busy running the apartment building which they owned and in which they lived. As a result, from her early teen years on, the cooking, cleaning, and sewing for the most part devolved upon the patient. There was also the invalid grandmother to take care of. The patient had to come home directly from school every day to take care of these duties, and she was not encouraged to participate in activities with other young people, or to invite them to her home. The patient returned repeatedly to these complaints about her foster parents.

Seven years before she came for treatment, the foster-parents had adopted an infant boy who had been found abandoned in a nearby alley a few hours after birth. Taking care of this child, little Bobby, also became chiefly the patient's responsibility, though it was one which she rather enjoyed. But she complained bitterly that the foster-parents had allowed his teeth to become decayed through neglect, just as had happened in her own case. She was also bitter about the fact that her foster-parents had decided that she should not have any children

because of her health, and had talked her into setting aside the rules of the (Catholic) Church and practising birth control. She added that since giving up contraception some time ago, she had been worrying if anything might be wrong with her, because she was still not pregnant.

V.

In her fourth hour, her first on the couch, the patient unwittingly gave her first hint of what she hoped for from her treatment.

She told of her husband's having protested because she had stayed out until 11 p.m. one night recently to visit a sick woman acquaintance. She had promised to be home at 8 p.m. She agreed that he had every right to be angry, just as her mother had done on similar occasions earlier. She added that if the analyst should change her in therapy, it would be unfair to her husband, because then he would not have the submissive, dutiful wife he had contracted for.

In other words, she was already hoping that the treatment would free her from her compulsively compliant attitude.

In the next hour, she reported a dream about an overflowing sink.

Dream: A sink was leaking onto the floor, but I couldn't see where the water was coming from. It went on and on. I kept trying to mop it up but it was an endless job, it went on and on.

The analyst asked whether the overflow was clean or dirty. The patient 'guessed it was clean.'

In the next hour, she admitted that she had not reported the dream honestly. With much squirming, embarrassment, and painful affect, she confessed that it was not a sink but a toilet that was overflowing. It was filthy, not clean. 'I have a quirk', she added, 'I could never talk to anyone about sex, and I hate dirty stories.' She explained that it was due to her Catholic education. The nuns in school were always talking about chastity, but she did not know what that meant. She would never have got married if she had known what the priest was going to tell her just beforehand

—that sex was not a sin after marriage, that her duty as a Catholic wife was to have intercourse as often as her husband wanted it.

It is evident that the patient had come to her analysis with an intense conflict about sexual thoughts, and much conscious guilt and shame.

A dream reported in her tenth hour next gave evidence of how the patient hoped that the analyst would help her deal with this sexual conflict:

Dream: I was at work. Mr B., the assistant boss, came out of his office—he is rather indifferent and cold—and stood in front of my desk and said matter-of-factly that he thought that I should go out and have a sandwich. Much later I was with a group from the office having dinner, and hoped that he didn't think that I was eating because he told me I should.

In association she added that Mr B. had recently been calling another girl in the office to ask about mistakes the patient had made. She protested to the analyst that she did not want any special consideration because she was ill. The analyst, taking the dream as a reference to himself, suggested that she felt that he, too, was telling her she could have something for herself. To this permissive remark she immediately gave a sexual meaning: 'A speaker at a parent-teachers meeting¹ the other night said that it was up to the parents to teach their children that sex is a beautiful thing, and that they should warn them against making fools of themselves.'

This dream well illustrates the importance of keeping our attention focused on the patient's preconscious responses to her treatment. We might be content to interpret it only as evidence of the patient's sexual transference wishes towards the analyst. Were we to do so, we should miss a more superficial, but much more significant, preconscious hope oriented towards the therapeutic situation. The key to this hope is the exact form of the manifest dream content. The patient is hoping that the analyst will play a role similar to that of the priest who spoke to her just before her marriage. She is hoping that the analyst will now tell her that she should enjoy sex.² She is reacting to this hope with great embarrassment. She repudiates it most energetically. She is shocked at the idea that the

¹ She was attending a parent-teachers' meeting at Bobby's school.

² It was the patient and not the analyst who related his permissive remarks explicitly to sex.

analyst might think she would be receptive to such a suggestion.

This dream also illustrates the fact that our patients must energetically repudiate the therapeutically significant hopes inspired by the treatment. This fact is understandable. If these hopes had not been unacceptable to the patient's ego, they would long ago have exerted their therapeutic effect and the patient would not have had to come for treatment.

It was a sign of the patient's growing response to the analyst's tacit support that only three hours later she was able to tell of some disturbing memories.

In hour 13 she asked for further reassurances that her material was confidential. Then she said that there was something which she could not confess even to the priest. The story came out with agonized affect and many pauses:

One summer night in South Dakota when the patient was 12 or 13, her father was driving her home from her uncle's.—He had been drinking. It seemed like a nightmare!—He told her that she was so much like her mother, then asked how long it had been since her last menstrual period and said that he wanted to do something with her but couldn't take the chance.

In the following hour the patient concluded that she might as well tell it all. She went on to confess sexual activities, which she at first thought were actual intercourse, with an older brother during several subsequent summers in South Dakota. When she met this brother, Harold, on her first vacation there, she found him so considerate and obliging that she wished he had come to Chicago with her instead of her younger brother, Lewis. 'But after the first few summers things changed. There was all that attraction, all that filthy petting and stuff . . . I think I was probably as guilty as he was . . . I'm so disgusted with myself for letting things like that happen. It didn't matter to him. . . . He tried to do it, but I wouldn't agree. Then he said I had no right to get him all bothered and then not give in to him. But I didn't, I don't know why. I knew every summer that I should not go up there, but no one knew anything about it and I couldn't give any good reason for not going.'

The hours that immediately followed these

confessions were for a long time baffling to us. For a long time we were unable to find a continuing dynamic chain of events that could make these next few hours intelligible as part of a therapeutic process. Then, finally, it began to dawn on us that the hopes directed towards the therapy that we had already recognized gave us the key to understanding what happened next.

The reasoning that led us to this insight was as follows:

Why, we asked ourselves, must a patient's therapeutically significant hopes be repudiated as they begin to emerge? Our answer is that they are related to hopes that were once very important in childhood but had to be rejected because they were associated with disastrous consequences. In view of this fact, we must expect that the beginning emergence of similar hopes in the therapy will soon be followed by beginning mobilization of disturbing emotions arising out of the old traumatic memory.

With this thought as our clue we shall now review and try to understand the next period (hours 16 to 30) in this patient's treatment.

In her sixteenth hour, the patient told of old fears. In her delirium at the time of her acute attack of ulcerative colitis, she might have talked about her sexual play with her brother.

In the seventeenth hour the patient expressed fear that her dentist, the one person aside from her husband whom she had told about her analysis, would tell her family of it.

Her next (eighteenth) hour she opened with a period of silence. Then she asked abruptly, 'Do I have to hate my parents?' The analyst asked what she meant. She continued: 'Dr E. said I have to learn to hate them; she said I had every reason to. Then I went home and hated her instead. But I really don't think I ever hated anyone. Oh, I'm all mixed up! Maybe I did hate them.'

Why, we must ask, does this question of hating her parents come up now?

Instead of answering our question, the patient told of another incident which would tend to justify her hostility towards her foster mother: 'Once my mother gave away a doll that I liked, and she didn't tell me about it. I decided to punish her by never playing with another doll, and I didn't. I wouldn't tell her why I wouldn't play with them. It was the satisfaction of knowing that it bothered her. I must have been stubborn or I would have

forgotten about it. At first I thought that she had no right to give away my things, but later when she did it I felt that nothing was really mine, and then it didn't bother me so much. About the doll I knew that she would have said, "That poor little girl has nothing. You should be glad to give her your toys." The things came out of her pocket in the first place, so she had the right to take them back and give them away. I never felt anything was really mine, it was just mine to use. I guess it's too bad I didn't throw tantrums when I was a kid.'

We are impressed with this patient's attitude of pious resignation towards her foster-mother. We are also impressed with her profound reaction to the loss of the doll. She herself explains her reaction as one of spite against the mother, but this hardly seems adequate to account for her resolve, which she actually carried out in later years, never to play with dolls again. Her explanation was a rationalization, hiding behind an aggressive motive the realization of how grievously she had been hurt. Her real motive was to protect herself from any possible repetition of her disillusionment by never letting herself become so attached to a doll again.

Why did this doll mean so much to her? We begin to get some inklings of the underlying traumatic memory from a dream reported in the next hour.

Dream: A girl at the office was showing me some jewellery in a box. She said it was jewelled initials for a purse. They were my initials.

She recalled that the foster-mother once gave her some initials for a purse. They were the wrong kind, but, of course, she couldn't tell her. The girl in the dream is only an acquaintance whom she sees at lunch. She is nice, a happy person, good company. The initials might have been hers, too; she has the same first name as the patient. They were hard to read, like fancy script. She couldn't be sure they were her initials, and she wanted to look again, but avoided it. She thought they were R.B., her initials before she was married.

She has had so many names in her life. She recalls resentment at the foster-parents' changing her last name to theirs even though she was not legally adopted. She had thought of running away. She tells of her embarrassment whenever the fact that her name had been changed comes out, usually in connexion with legal documents and records. The girl in the

dream once said at lunch that she was glad to change her name when she married. She also liked it when she heard this girl once mention having to go over and help her mother clean house, while her husband stayed at home and slept.

In the next hour, the patient again said that the girl who figured in her dream had remarked at lunch the other day that she was glad to have got rid of her maiden name when she married. The patient admitted that she liked this girl, and again mentioned her speaking of having to go over and help mother clean house on Saturday. She was struck by the fact that this girl didn't seem to mind.

A little later her thoughts reverted to the time when she was first brought to Chicago. 'They said that Lewis wouldn't eat a strange dish when we came to Chicago unless I ate it first. My grandmother remarked, "You'd think that the food was poisoned." I suppose it's hard for kids of that age to go into a house full of strangers and accept everything.' After a silence she continued: 'I think changing my name when I married bothered me, I don't see why it had to be that way. It seems as though you give up your identity or something.' The analyst agreed, and brought this feeling into relation with the loss of her own parents, adding that perhaps she always wondered what she did have that was her very own, that could not be taken away. 'Yes', she replied, 'but isn't it that I'm not able to adjust myself? If that was the way it had to be, I should have accepted it. They had a right to take away what they had given.'

Again we are struck by the patient's attitude of fatalistic resignation.

For a long time we were unable to understand this dream. Finally, the patient's twice repeated reference to the girl who did not mind helping her mother gave us the clue.

The patient, herself, is longing for a good mother-daughter relationship, but the treatment seems to be leading her in a direction that threatens her relation to her foster-mother. 'Do I have to hate my parents?' she had asked. Hating her foster-mother would destroy the possibility of a good mother-daughter relationship.

Now we must ask: Why does she expect the analyst to tell her she must hate her foster-mother? And why is she so afraid of losing her mother?

In the light of her history we can understand why she so longs for a mother. When she was barely 4 years old she was suddenly deprived of her true mother by death. Then she expected to stay with her father, whose favourite she thought she was. Yet, only a few months later, she was sent away to strange foster-parents and had to change her name. From the associations of the last two hours we can reconstruct the impact that these events must have made on her. Unconsciously she is talking about herself when she remarks how hard it is to go into a house full of strangers. The way that she dwells on the change of her name reflects her feeling at that time that she had completely lost her identity. First losing her mother and then being sent away to strangers by her father must have left this little girl with a feeling of being utterly uprooted.

No wonder that her longing for a mother is so intense! The trauma of being uprooted must not happen again! At all costs, she must see to it that her hostility does not cause her to lose her foster-mother too. Hence her resigned, submissive attitude.

This patient's questions about hostility towards her foster-parents had emerged suddenly not long after her confessions about her sexual play with her brother.

To account for this fact we recall that her mother's death occurred when she was a little over 4 years of age, when she must have been at the height of her Oedipus complex. We also know that she was recognized as the father's favourite before she came to Chicago, that he liked to take her with him on his rural mail delivery rounds, etc. Putting this together with the later account of his sexual advance, we may surmise that his relationship to her even before the mother's death had been a seductive one.

Now, in her treatment, the reawakened memories of the father's sexual suggestion and of her incestuous play with her brother have begun to make her aware of where her hopes of sexual release (as a result of the analysis) are leading her. In order to be released from her sexual inhibition she would have to break away from her desperately submissive tie to her foster-mother. Dr E. (the internist at the hospital where she had been treated for her colitis) had actually advised her to leave home. She had assured the patient that she had every reason to hate her parents; but the possibility of hating her foster-parents and leaving them only reactivates the memory of how completely uprooted she felt

when she really did have to leave home to go to live with strangers.

The intensity of her reaction to the doll incident also begins to make sense. The doll had served as a substitute, consoling her for the loss of her mother. In her fantasy she had probably given to the doll the mother whom she herself had lost.

Relating back to an earlier fantasy, the doll was probably also a baby that she had wished that the father would give her—just like the baby that he was giving her mother. In reality, instead of giving her a baby, he had sent her away to strangers. Indeed, intense resentment of this disillusionment by her father was the one emotional reaction to these events that had persisted in consciousness until the time of her treatment. For example, in her 11th hour, while discussing her feelings towards her foster-parents, she had suddenly blurted out, 'I didn't see how anyone could honour my own father.' She added vehemently, 'I didn't matter much to him, so why should he matter to me? Obviously he didn't care a hoot about us. I wouldn't let a family of mine be split up. I suppose I'll always hold that against him.'

Thus this patient's Oedipus wishes seem to have culminated in the wish for a child by her father. This was followed by the death of her mother, and then by the loss of both her home and her father. In view of these disastrous consequences, it is not surprising that she became a compliant, good girl, in this way clinging desperately to her new home and her new mother. Now she must fight off energetically any hope of being freed by the treatment, any thought of permitting herself to enjoy sexual pleasure.

In these last three hours the patient has given us a glimpse of a traumatic memory of great intensity. However, what happened next in the therapeutic situation was not at this level. At this time, she did not relive this traumatic experience in her relationship to the analyst. This was fortunate, since at this time her ego would have been utterly incapable of mastering such an intense shock of being uprooted.

At this time the ongoing therapeutic process was focused on preconscious hopes much closer to her real relationship to the analyst in the therapeutic situation. To discover these hopes we turn again to the manifest content of her dream.

Dream: A girl at the office was showing me some jewellery in a box. She said it was jewelled initials for a purse. They were *my* initials.—I wanted to look again but avoided it.

From this dream we now conclude that she is hoping that the analyst, represented in the dream by the girl, will restore to her (show her) the memory of the close relationship she once had with her own mother. Yet, in the dream she must avoid even looking to see whether the initials in the purse are really hers. The memory of losing her mother (and of the events that followed) is so traumatic that she must shrink back from even looking at it.

Can this insight help us understand the treatment hours that immediately follow?

In her 21st hour, after a silence, the patient suddenly asked, 'Why do I want to live without emotions? I can't remember ever having been hurt *that* much. I just want everyone to leave me alone.' She continued with feelings of guilt towards her husband. 'I feel that Joe was terribly gypped when he got me for a wife. He deserves something better. His relatives are so interested in us, but I don't ever want to be bothered with them or to have to talk to them on the phone. Yet I like them, too . . .'

Continuing this theme in the 23rd hour, she protested that she had never wanted to ask her foster-parents for anything. 'I don't like to accept things from them even now,' she continued. 'Things they give me seem like a bribe . . . I don't think they ever gave me anything because they wanted to. They did it for their own reasons.'

In this series of hours we detect a new trend. In her introduction to her usual complaints about how badly her foster-parents treated her, we learn that she is really more distressed when people treat her well, as, for example, in the case of her husband's relatives.

At the close of the 23rd hour, the analyst pointed this out to her. He remarked that she seemed to need to feel herself unloved and exploited and to get gratification out of self-commiseration.

This interpretation made a great impression on her. She could not sleep that night. In the next hour, she wondered if 'all this colitis and stuff' was not something that she had because she enjoyed it. A week later, she was still

worried. She had been unable to sleep ever since the discussion of the week before.

In the 26th and 27th hours, she unexpectedly brought her concern into connexion with sex. She told of her unhappiness in her marriage because of her feeling that sexual relations are disgusting and abhorrent and often painful. She wants her husband to 'leave her alone'. Instead, he insists on intercourse almost every night. She continued, almost moaning, 'How can I stop feeling sorry for myself or enjoying it? I think that is what is wrong with me about sex. That discussion last week bothered me. I thought maybe there must be some reason . . . I just about decided that I spoiled . . . (laboured and gasping breathing) . . . that I spoiled sex by feeling sorry for myself and feeling abused.'

Thus, for the first time, this patient is consciously calling into question her whole masochistic orientation and in particular her repudiation of sexual pleasure. This beginning realization that she has 'spoiled sex' may well be an important step towards therapeutic progress. It implies the possibility of her taking seriously an emerging hope. Perhaps her repudiation of sexual pleasure is unnecessary. Perhaps it is something from which her treatment can free her.

We know, however, that such a masochistic pattern cannot be given up easily. We must expect that her new hope of sexual release will be followed promptly by reactivation of the underlying fears that had made it necessary for her to 'spoil sex'.

In the next (28th) hour, she asked suddenly, 'After a woman has five kids, is she apt to be nervous in having the next one?' She went on to explain that yesterday was her 28th birthday and that her grandmother often told her about her mother's becoming nervous before she was born because the doctor was away. She continued, 'I was wondering if she was a coward. I don't think I'm afraid of pain. I'm conscious of being close to 30, and you should have kids when you are young.'

We know that the patient's mother later actually died after childbirth. Preconsciously, the patient seems now to be wondering whether she too must die in childbirth, probably in retribution for her own earlier death wishes against the mother, which had been fulfilled by the mother's death.

Her anxiety began to take another form in the 29th hour. 'Have you talked to my family?' she asked. Her foster-parents and her husband had suddenly become much more agreeable to her wishes in small things, so that she thought that the analyst must have been talking to them. The analyst told her that he had not contacted her family, but that perhaps she wished that he would. She vehemently denied any such wish, but the next hour she berated herself for having been so stupid as to distrust him. She added that she would not have come back again if she had not been sure that he had not communicated with her family.

For a long time we were puzzled to explain why this sudden distrust of the analyst had emerged just at this time. Then it dawned on us that this, too, was a logical consequence of the hopes that she had been preconsciously entertaining. She had begun to anticipate the probable consequences of her hopes that the analyst would make her freer sexually. If he did, what would her family say? Then a possible solution had occurred to her (preconsciously). Perhaps the analyst might talk to them and secure their acquiescence in what he was trying to do for her. This preconscious hope actually became conscious in a less disturbing form. She suspected that the analyst really had talked to them. That was why the parents had been nicer to her lately. However, her disturbed reaction to this seemingly pleasant thought betrayed her underlying intense need to repudiate this dangerous hope. If the analyst should tell the parents of her hope that the treatment will give her sexual release, there is no question in her mind what their reaction would be.

VI.

At this point, we shall interrupt our detailed report of this patient's therapeutic sessions. We shall skip ahead to a later dream in which the hopes that we have just reconstructed came to overt expression.

This patient's basic character defence was one of masochistic submission to her foster-mother. Even after her marriage, she continued to do many household chores for her foster-mother, in addition to holding down a full-time job, and also working hard taking care of her own home. All this did give her sufficient justification so that she could do a great deal of griping about her foster-mother,

as well as about others. Although she herself was always accepted as the compliant, good girl, she also spent a good deal of time in her therapeutic sessions complaining about others on the job and elsewhere who got away with things. She had especially mixed feelings towards her brother, Lewis. On the one hand, she was protective of him and his wife in their conflicts with the foster-parents; but she also expressed rather openly her envy of him because he had been able to get his own way much more than she. She was especially envious of him because he had finally been able to leave home after his marriage and to establish himself in another town some hundreds of miles away.

In the therapeutic situation, whenever the patient recoiled from her hopes of release by the treatment, this whole masochistic pattern was intensified, together with her griping protest against it. Her rebellious protest became stronger and more determined whenever she began to feel more secure in the analyst's support.

A particularly good opportunity for such a rebellious protest was reported in the 76th hour—when her brother Lewis was evicted from his home. At this time he asked the foster-parents for a loan so that he could buy a trailer for himself and his family. This, the patient said, would put him just where his parents wanted him—under their domination. She was sure the foster-mother would manoeuvre him back into their apartment building and make him work there as janitor. To prevent this, the patient herself secretly offered Lewis a loan in case the parents should refuse. When they did refuse, she let Lewis have the money.

Her reaction to this secret defiance was the following dream, which was reported in her 80th hour, just after Lewis and his family had left the foster-parents to drive back to their own home.

Dream: I was in the apartment downstairs. My parents and I were at the door saying good-night to some callers who were leaving. I thought they would never go. When they finally did, I went into the dining room and you were there. I had realized that you were in the apartment, that was why I was anxious for them to leave. Then you were talking to my mother. She looked as if she was pretty sore. You sent me out of the room, indicating that you could fix it up. I wondered how I was

ever going to explain this. I thought I had put you in a heck of a spot because I knew you were there, they didn't. I was responsible for you being there and the least I could have done was tell them. I was willing to let you try to fix it, but you didn't know what you were up against. As far as I know, no one has ever crossed her yet. At the end of the dream I looked out the front window, and there weren't any sidewalks, rather deep trenches in their place, but it didn't seem unusual or remarkable.

Her only association was to recall how hostile the parents were towards the doctors at the hospital because they had told Lewis that his asthma had an emotional basis and had advised his getting away. In the light of this, she was awfully glad that she had never told them anything of her treatment 'here'.

This dream illustrates a principle that we believe to be very important for the understanding of psycho-analytic therapy. The principle is: As soon as a patient begins to take her hopes seriously, she must reckon seriously with the consequences and find a plan for dealing with them.

Our patient is nourishing hopes of becoming free of her foster-parents. With the encouragement of the doctors at the hospital, Lewis did leave the parental home. Now, by lending him money, she herself has just been supporting him in his desire to remain independent. In this way she is living out vicariously her own wish to become free. She is already preoccupied (consciously) with fear that they will find out what she has done. This time she dreams openly of her hope that the analyst will intervene for her with her foster-mother. But, her dependent need for the mother is too great. She cannot conceive how even the analyst's support could prevail against her foster-mother.

VII.

At the beginning of this paper, we called attention to a fact which we all know but which we sometimes forget when we try to understand the therapeutic process in a psycho-analytic treatment. The influence of the therapy on the patient's neurosis is not exerted directly on the patient's deep unconscious but rather at the level of the conflicts that are focal in the system pre-conscious.

Just below the surface of the patient's consciousness, in every analysis that is progressing

satisfactorily, there is a continuing interchange, a kind of dialogue, between the analyst and the patient's preconscious ego. It is at this level and in this way that the effective impact of the therapy on the patient's behaviour is achieved.

In this paper we have just been trying to follow and understand such a dialogue. We shall now summarize briefly the main steps in this interchange between the analyst and the patient's preconscious ego.

In the first twenty hours of her treatment, our patient's dawning hopes of release from sexual inhibition had begun to awaken a traumatic memory. Early in her childhood, she had entertained sexual wishes towards her father and fantasies of having a child by him. Then her mother died and she lost both her father and her home. She was left with a sense of having been completely uprooted—abandoned to the care of strangers. Now, in the therapeutic situation, this memory was so disturbing that she was compelled to shrink back from looking at it. An old defence was reactivated, a shrinking back from all emotions. She had to shrink back especially from human contacts that threatened to reawaken her own deeply traumatized longings for affection.

At this point, the analyst entered into the conversation, calling attention to her need to pity herself, to feel herself unloved and exploited. This interpretation caused the patient great distress, which disturbed her sleep for over a week. Behind all this distress, however, a therapeutically significant hope was hidden. The analyst's interpretation of her masochism had reinforced once more her hope of sexual release as a result of her treatment. This time her reawakened hope was based on her beginning realization that she herself was 'spoiling sex' quite unnecessarily.

Still the dialogue in the patient's preconscious continued. Again her hopes were answered by fear of inevitable consequences. What would her foster-mother think? Her preconscious ego answered with a new hope. Perhaps the analyst might intervene for her with the foster-mother. However, even as late as her 80th hour, the patient's hope of support from the analyst was no match for her desperate need to cling to her foster-mother.

VIII.

If time permitted, we could trace this kind of a dialogue all through this patient's very long treatment. Within the limits of this paper we

shall have to content ourselves with a very brief summary of how some of her hopes, after being repeatedly repudiated, could finally be accepted in consciousness and find fulfilment in real life.

It was imperative for this patient to get some kind of parental support for her wishes for sexual release. When she finally realized that she could not expect such support from her foster-mother, she turned next to her husband.

Just before marriage, the priest had instructed her always to yield to her husband's sexual demands. These instructions furnished the justification for her marital adjustment—on condition, of course, that she must not enjoy it. Later, her glimpse of the possibility of enjoying sex led to an intense reaction formation. She began to find excuses for refusing her husband. He, thus provoked, would not be put off. He became all the more insistent and demanding. On a number of occasions, he had intercourse with her while she was asleep and she succeeded in sleeping through it, only realizing in the morning what must have happened.

Under these circumstances, it is understandable that her husband should wish that the treatment would produce some change in her attitudes towards sex. The following dream reported in the 133rd hour is one of several that seemed to be trying to put her husband's authority behind a hope, which she herself must repudiate, that the treatment might change her sexual attitudes:

Dream: 'Sunday morning while I was putting my shoes on I remembered that Joe said that some of my shoes needed repairing. I asked him which ones it was, and he said that he had never mentioned anything like that. So I must have dreamed it, but I can't remember the dream.' [Silence].

In association to this dream, she spent the whole hour complaining vehemently about her husband's sexual demands on her.

Another dream, reported months later, revealed that this hope had been allowed to develop much further before being repudiated.

Dream: 'Sunday morning I recalled that I had been dreaming that I had been cooking cabbage. I was thinking that he (the husband) was going to be very pleasantly surprised to find this in the house.'

Her first association repudiated this wish.

The patient and Joe don't have cabbage because she cannot eat it and Joe does not like it.

As in other dreams of this patient, food has been substituted for sexual gratification. The dream has chosen a food that neither the patient nor her husband like in order to repudiate her hope of 'surprising' her husband by enjoying his sexual demands.

Once before this (in her 165th hour) the patient had reported having enjoyed her sexual relations with her husband. It was only much later that she came to accept and enjoy the marital relationship consistently.

The doll incident, reported as early as the patient's 18th hour, has already given us a hint that wishes for a child must have played a very important part in her childhood. They were later energetically renounced as a protection against disillusionment. Later in her treatment, this wish emerged repeatedly and was repeatedly repudiated.

The following dream was reported in her 102nd hour:

Dream: 'I dreamed that I woke up in the morning and somebody said that I had given birth to a baby. I didn't know about it—everyone knew more about it than I—I was showing the baby to someone, but it was more like showing off a new dress or coat.'

The background for this dream was the fact that her foster-mother had been remarking what a shame it was that Joe didn't have any kids—since he got such a bang out of them and liked to fix up Bobby's toys so much.

During this period and for a long time afterwards, this patient's wish to have many children (like her mother) was finding expression chiefly in a vicarious form. The patient's foster-mother was very critical of Lewis's wife, Helen, because she was having pregnancies one after another with almost no interval between them. The patient protested defiantly on Helen's behalf that she had a right to have children just as often and as many as she wanted to.

It was not until two years later that the patient herself first thought consciously that it would be nice to have a baby of her own. The thought came to her while she was looking at patterns, in order to make some baby coats for Helen's children.

We recall that early in the treatment the patient had very much envied her brother

Lewis's having been able to move away from the parental home. Then, by lending him money, she had given vicarious expression to her own desire to do the same. Still, in her dream at that time, she had been unable to conceive how even her analyst could prevail against her foster-mother.

Some months after this, however, she and her husband began to dream and then to plan for their building a house of their own in the suburbs. Her unconscious resistance towards these plans took the form at first of exaggerating enormously all the practical difficulties that intervened to delay them. As the plans came closer to realization, she became much alarmed at the thought of how offended her foster-mother would be. These fears, too, proved to be much exaggerated. The foster-parents finally became fairly well reconciled to their leaving. In the patient's 415th hour, she reported, though with a characteristic lack of enthusiasm, that they had actually made the move. In spite of her disavowal of enthusiasm, her satisfaction in the new house became more and more apparent in the succeeding months. Finally, she resigned from her job in order to be able to spend more time in her new home.

We hope that these few episodes will suffice to illustrate the fact that the therapeutic hopes this patient brought with her at the very beginning were all premonitory of the therapeutic progress that she was actually to achieve in the course of her very long treatment.

IX.

We shall conclude by summarizing our concept of the therapeutic process—based on our analysis not only of this one case, but of others as well.

In rational behaviour the subordination of behaviour to purpose is made possible by integrative capacity based on hope of success in carrying a plan through to execution. We believe that hope plays a similar role in psycho-analytic therapy. Specific hopes, oriented always in part towards the realities of the therapeutic situation, keep emerging. Such hopes are essen-

tial for maintenance of the gradually increasing integrative capacity on which success in therapy depends.

Unfortunately, these therapeutically significant hopes are closely associated with other hopes from the past which once ended in disastrous consequences. For this reason, the newly emerging hopes must at first be repudiated. Unless they are promptly repudiated they begin to reactivate the associated traumatic memories.

At this point, the analyst can help by giving explicit recognition to the present realities towards which the patient's new hope is oriented. He should also explain that the patient's need to repudiate her new hope is a consequence of disturbing events in the past.

The therapist should not expect such an interpretation to have an immediately beneficial effect. The immediate effect of his interpretation will be weak indeed in comparison to the patient's own need to repudiate her new hope. If the associated traumatic memory pattern has begun to be activated, the patient may be preoccupied for weeks or months with disturbances resulting from this reactivation.

The therapist's interpretation is designed not for present but for future effect. Ultimately, he expects, the disturbing affects will be dissipated or discharged. Then hopes similar to those that were repudiated will begin again to emerge. When this occurs, he expects that his earlier interpretations will have had a latent effect. His previous explicit recognition of the patient's new hopes will have increased their integrative capacity, even though they have remained latent. Now these hopes will emerge more boldly and persist longer before they are repudiated.

The analyst must remember that it is not his own hopes but the patient's repudiated hopes that need recognition and encouragement. In order to achieve the maximum therapeutic effect, he should be alert to recognize therapeutically significant hopes even when they are only hinted at. If he can recognize the patient's own emerging hopes early and repeatedly, he should be able to hasten very much the patient's ultimate recovery.

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ASSIMILATION OF UNCONSCIOUS MATERIAL

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The derivatives of unconscious conflicts that reach awareness during the course of a psycho-analysis are assimilated in a variety of ways, depending upon the psychological forces that are prevalent at the time awareness occurs. The nature of the assimilation process and the factors influencing its form are the subject of this paper.

Assimilation is delineated by Hartmann (1958) as a cognitive process, and this meaning of the term is utilized here. He states that 'defenses not only keep thoughts, images and instinctual drives out of consciousness but also prevent their *assimilation* by means of *thinking*. When the defensive processes break down, the mental elements defended against and certain connections of the elements become amenable to recollections and reconstruction. Interpretations not only help to regain the buried material but must also establish *correct causal relations*—that is, the causes, range of influence and effectiveness of the experiences in relation to the other elements.' He views the process of assimilation as a highly organized type of mental functioning that *involves thinking* about correct connexions and establishing causal relationships between the various previously isolated elements.

The psycho-analytic process leads to changes of a broader character than those involved in the assimilation of recovered conflicts by way of thinking (Bibring, 1937). Yet the economic, dynamic, structural, and adaptive changes that follow psycho-analysis and which may be manifest in new ways of tolerating and expressing affect and in more organized ways of behaving do not occur without the intermediary effect of complex types of thought process. The manner in which a recovered conflict is thought about will have a direct, although by no means exclusive, influence upon the nature of the affective and behavioural responses that follow the thinking.

At best these cognitive functions of the ego are only relatively autonomous. Even after a

successful psycho-analysis, they have a defensive aim, concomitant with their value in assimilating the nature of the recovered conflicts. Glover (1955) has emphasized that the psycho-analytic process is 'limited and hampered by the same mechanisms as once helped preserve the ego from its unconscious taskmasters, the id and the superego'. The assimilating functions of the ego will be all the less autonomous the earlier and more urgently the instinctual conflicts have evoked defensive processes.

Freud (1937) has described several types of resistance which hamper the psycho-analytic process and limit its effectiveness. He points out the difficulties in conducting a psycho-analysis where there is excessive strength of the instincts or where there are either inherited or acquired defects of the ego. In the more marked situations of this kind, an intractable transference resistance or a resistance to the transference neurosis will persist and the evolution of the observing and assimilating functions of the ego will not occur. Even where a transference neurosis has developed and a therapeutic alliance has been established so that there is the possibility of meaningful interpretations of defences and instinctual derivatives, the ghosts of long-established, though partially resolved, neurotic patterns haunt the ego as it tries to make connexions between the various mental elements.

A comparison of the mode of assimilation manifest during the early stages of a psycho-analysis with the methods apparent at the termination of the treatment is helpful in understanding the forces that promote or limit the development of such important functions. The best opportunities for making such comparative observations are during relatively similar periods of stress, mobilized either by the analytic situation or outside the analysis, which are reflected upon by the patient when the turmoil has somewhat subsided. It is clear, however, that these changes may take place without being obvious in those thought processes

that are accessible to the analyst. Many thought processes occur either on a peripheral preconscious level or else outside the analytic hour. The patient, like the analyst, may assimilate a stressful situation as he is driving home at night. Another complication in understanding these changes stems from the fact that the patient's mode of assimilating recovered material during the psycho-analysis is strongly influenced by the transference neurosis. His need to please the analyst or to avoid being influenced by him may persist to the end of an analysis and will obscure what is likely to take place post-analytically.

If one is in the position to follow an analysand's reactions to a stressful event, one is usually struck by his initial employment of primitive defences, followed by his utilization of increasingly more autonomous appraisals of the situation. This is true whether the stress appears to be primarily external—i.e. where a strong press from the environment precipitates the patient's reaction—or appears to be primarily internal—i.e. where the environment operates largely only to trigger an intense instinctual response. The immediate reactions to such stresses are frequently the use of denial, projection, and repression, succeeded very often by thought processes that serve essentially to rationalize or disclaim a threatening meaning. At what point are we able to delineate thought processes as an aspect of assimilation rather than defence? Assimilation occurs when a delay has been instituted—a delay (Rapaport, 1960) which permits a shift from a primitive primarily passive mode of reacting to stress to a more integrated active one. The anlage for such a shift occurs in childhood when the anxious child, temporarily helpless in dealing with a stressful situation, is able to identify with his parent's more supportive attitude and begin to search for more 'realistic' aspects of the traumatic event which has rendered him helpless. It is the child's at least partial internalization of his parent's aim—to understand, to tolerate, and to master a threat—that forms the model for the process of assimilation.

Assimilation of External Reality

Whether the stress appears to be mobilized primarily from without or from within, the assimilation process itself is likely to deal with the 'external reality' of a stressful situation. There is a deeply-rooted tendency which influences even the most sophisticated types of mental functioning to locate what is unpleasant

outside oneself. It is less threatening to deal with and master the elements in the external world than to look at what is happening inside oneself. This tendency is manifest in many situations even after a psycho-analysis where attention has been repeatedly and apparently successfully directed towards the derivations of repressed conflicts.

It is useful to set up a simple schema. Let us assume someone is criticized and his initial reaction is to feel very threatened. This may be followed by a justification for the act he has performed that led to the criticism. This response may be of a somewhat less immediate order than an outburst of rage or denial, but it is still of a relatively non-integrated character—the superego is projected onto the critic and the justification is a reflection of a harassed ego fending off an attack. The case is not quite so clear if the criticized person begins to look for the motivation of the one who has criticized him—a reality feature of the threatening external world, or for practical ways to deal with the critic—the means of appeasing the external threat, or for the aspects of one's own behaviour that initiated the criticism—the stimulus for the external world's threatening reaction. It goes without saying that this kind of 'reality-testing' serves at least a partial defensive purpose. It helps to ward off an accurate appraisal of the action for which one is being criticized and, more significantly, it defends against awareness of conflictual wishes and deeds, past and present, which are at the bottom of the sensitivity to criticism. The more frantically and inflexibly one employs such forms of reality-testing, the more obviously the thought processes are in the service of defence and not part of a more integrated process of assimilation. Yet certainly in many instances, where there is less frenzy and rigidity, such observations of the external world appear to be relatively autonomous, may be useful, and even as far as such matters can be determined are correct.

However, criteria that are useful in ascertaining to what extent observations of external reality have become increasingly autonomous during the course of psycho-analysis—i.e. no longer primarily serve the aim of warding off awareness of the *significance* of external events as they relate to unconscious conflicts—are not readily forthcoming. The 'correctness' of an appraisal of external reality as judged by a common consensus of opinion is of limited value for this purpose. Repressive mechanisms operate

selectively, warding off from awareness the more intense derivatives of unconscious conflicts while permitting the less charged ones to be hypercatheted. By such selective observations and reconstruction of elements of the external world, it is possible to come to an understanding of this outer reality that is correct as far as it goes but still essentially avoids accepting those aspects of the environment that impinge upon oneself. A recognition that one's opponent is angry because of some unpleasant experience in his life may be a valid observation, but this knowledge will not help in understanding why one has been so disturbed by his anger.

This problem of understanding the extent of autonomy of assimilating the outside is complicated by the fact that, while the more conscious aspects of the assimilation process are focussed on the external elements of a threatening situation, there may be concomitant peripheral awareness of cues from within that alert the observing and assimilating ego to what is happening within oneself. It is not necessary to look far from home. Take the example of the psycho-analyst who is irritated by the protracted defensiveness of his patient. The deeper roots of his irritation may stem from frustration of his omnipotent, narcissistic wishes as well as from his envy of his patient's passivity. All that he may recognize, and this in a peripheral way, is an impulse to be sarcastic or possibly a tendency to give interpretations with somewhat of an edge in his voice. He may recognize as the result of such signals that he is over-reacting, and he may then be able to reintegrate his position *vis-à-vis* his patient so that he can tolerate the frustration of the latter's resistance and more or less correctly understand and interpret what is happening to the patient. The analyst's process of assimilation is most actively directed towards elements of his external world—i.e. aspects of his patient's behaviour. He is not likely at such a time to search for the source of his own irritation in his infantile conflicts. There is no reason to suppose that during this particular psycho-analytic hour he is actively aware of the meanings of his response to the patient. A reintegration or reorientation of his ego, accompanied by a potentiality for more adaptive and effective behaviour, has occurred without a concomitant assimilation of all the significant aspects of the stressful situation. The structural changes that are at the basis of this capacity for reintegration have been effected through the analyst's own psycho-analysis and post-analytic

working through, and certainly in part have been accomplished through the assimilation of the meaning of what are now his countertransference attitudes. Yet these structural changes which permit more appropriate adaptive responses to stressful situations, including increasing awareness of certain phases of the stress, do not necessarily involve the contemporaneous utilization of deep awareness of inner conflicts.

Gill and Brenman (1959) discuss at considerable length the concept of the ego's relative autonomy from the id and the environment. They emphasize that an increase in relative autonomy occurs when the ego is both able to resist pressure, whether coming from the id or the environment, and at the same time has access to input from these sources and is not oblivious to the meaning of this input. Applying this formulation to the external world—the environment in their term—a relative increase in autonomy occurs when there is awareness and toleration of the more unpleasant significances of an external event. Yet, many of us, at times, even after apparently successful psycho-analyses, employ a type of reality-testing that has the aim of decreasing the unpleasant implications of the external world rather than tolerating its more disturbing aspects.

There are indeed many situations where the external reality does appear more threatening to the individual viewing it than is warranted by the actual potential for danger—the fantasy overshadows reality. Frequently such fantasies of danger are defended against by the mechanism of denial. Reality-testing in such an instance involves counteracting the denial, becoming familiar with the source of the fantasied danger, and then finding evidence that in fact the potential injury or loss is not likely to occur. Clarifications of this sort are frequently made in psycho-analysis, and may become part of the post-analytic repertoire of techniques for testing reality. The analyst may indicate that in certain competitive situations the patient, without being aware of it, has the fantasy that in one way or another he sees himself as defective—a fantasy that is injurious to the patient's narcissism and his capacity to cope with the external world. A psycho-analysis may diminish the homosexual and incestuous conflicts that feed this sense of inferiority leading to meaningful structural changes; the patient may eventually be able to compare himself more correctly with other people—more adequately to assimilate external reality. Yet not uncommonly the motive during

periods of relevant stress for correcting reality is to reconstruct events so that the narcissistic injury is decreased—to recognize that he is less defective than he had fantasied—rather than to tolerate his actual limitations. In a similar manner, the reality-testing of situations, where a real possibility of loss exists, may include a recognition of the actual danger, but then the major aim of the thought processes that follow this recognition may be the appeasement, the recovery, the restoration, or the compensation for the lost object rather than acceptance of and mourning for the loss. The impetus once again for this kind of assimilation process is to alleviate pain caused by external events rather than to tolerate it. Toleration of the implications of an external threat requires a high degree of integration, characterized by capacity to delay immediate and compensatory reactions to the painful loss and to recognize and accept the affects and the implications associated with the external threat.

The ability to empathize indicates that there is considerable autonomy of the assimilation process. Yet extensive utilization of empathy at times precludes deep awareness of instinctual conflicts. Empathy of a high order involves both a capacity to identify with and to experience the mental state of someone else and at the same time to understand and assimilate the significance of this mental state. The patient to be described, significantly augmented during her treatment her ability to empathize, which was already quite highly developed before her psychoanalysis. Empathic understanding was one of the prominent methods she used for assimilating stressful situations at the end of her analysis. At such times she had insight into and apparently could assimilate elements of her inner reality, but her concomitant empathic reaction frequently served to defend against awareness of herself. It is postulated here that there were genetic factors which fostered a talent for empathy and yet made difficult the development of certain kinds of insight.

Case 1

The patient is a divorced mother who was treated over a four-year period while she was in her late twenties. She is an intelligent, sensitive, creative individual who entered analysis because of great difficulty in her relationship with men. She had a disturbed childhood. Her mother was a compulsive, depressed woman who had abandoned the

upbringing of her children to a maid who left when the patient was 6. Her father, a successful, energetic professional man, had a close relationship with the patient during her earliest years, but divorced his wife when the patient was 5 and remarried shortly thereafter. The patient had been a friendly, lively child whose intellectual curiosity had been highly praised by her nurse and her father. She had been taken by her father on a number of occasions to watch in the theatre an actress who was his mistress and subsequently became his wife. The patient was intensely stimulated and frightened by the implications of these experiences, but for a while quite successfully reconstructed her external world as non-threatening. The fact that these visits, while foreshadowing the desertion of her father, were quite pleasant and interesting and that both her father and her stepmother-to-be were very supportive and affectionate on these occasions gave substance to her fantasy that happier days were to come. This fantasy from one point of view denied the indications she had of the impending marital breakup and helped repress the frightening emotions mobilized by such perceptions; yet, from another point of view, was not too discordant from reality. When indeed her father did leave, she attempted to cope with her loss by 'seeing' why he had behaved in the way he did. The understanding and curiosity which had been fostered by loving relationships was now to some degree autonomous, but used in the service of defence. Eventually, after a long period of turmoil, the divorce became final, and she felt deserted by her father. She attempted to deal with her feelings of rejection by transferring her affection to animals and to helpless people and by behaving in an indifferent manner with her parents and other grown-ups. Towards the end of her adolescence, this indifference thawed out, and she became involved in a series of intense masochistic love relationships, culminating in an unsuccessful marriage. Her ability to understand the feelings of people who let her down was outstanding, except at times when the loss was very acute. During these periods she was helpless and moderately depressed.

The early stages of the analysis were characterized by my implicitly and sometimes explicitly setting limits to her wish for closeness, which was very much of a pregenital order. I indicated in effect that it was all right

to want love, but that it could not be gratified in the form demanded.

During the course of her psycho-analysis there was much working through of repeated disappointments in the transference, with the development of considerable awareness and increasing tolerance of her reactions to loss. The patient became aware not only of many of her responses to disappointment, but also began to appreciate that neither she nor anyone else was capable of ceaseless loving, a hope that she had always cherished, although she had denied this wish during her latency period and had attempted to counteract it by her independent behaviour. Nonetheless, throughout the analysis, right up to its termination, the old longing for an all-loving parent persisted, although in a definitely attenuated form.

As the intensity of the infantile craving decreased, she was able to establish a transference neurosis of a more classical kind. She became aware of intense oedipal fantasies through her experiences in the transference setting. She began to recover many memories of a positive early relationship with her father and was able to evaluate him more realistically. She became acutely aware of her own fear of punishment which was present in any sexualized experience.

She was never able, however, to experience a major rage in the transference situation, and her awareness of her hostility towards me for frustrating her was of an intellectual rather than of an emotional type. She was eventually able to express in dreams and fantasies derivatives of anger towards her idealized objects when they had disappointed her. She was able to behave much less dependently and masochistically, and her relationship with men became much more mature and genital. Yet even with her love objects, situations which would have angered many people evoked in her more understanding than fury. This capacity to empathize very accurately with the mental state of the 'disappointing' love objects was an outstanding feature of her process of assimilation at the time the analysis terminated. She was capable of recognizing, to an unusual extent, the feelings, motives, and significance of the behaviour of other people. This could be verified in the transference situation. Her assessment was unusually precise unless she was intensely disappointed.

This woman was not aware of the full

extent of her anger when she was rejected, because she was fearful of its destructive implications. Her process of assimilation at the end of psycho-analysis did include an understanding of many important aspects of previously repressed conflicts associated with incestuous desires and rivalry situations, but a major feature of the assimilation at such times included a need (as well as a capacity) to recognize the mental state of the frustrating love object. This post-analytic 'fault' appeared to reflect an early mode of dealing with the losses in her childhood—a method of dealing with such stress which had been first fostered by early loving identifications with the maid and her father and had been reinforced by the fact that an empathic understanding of their desertions served to dampen the narcissistic blows and the rage mobilized by such losses. Her psycho-analysis further nurtured this capacity, which was of help in tolerating the fact of rejection and in counteracting her angry feelings stirred up by rejection. Her empathic understanding also helped her in her management of object relationships and helped to maintain the object in reality. At times when she had to separate from a love object, empathic identification served to preserve the object psychically and convinced her that she had not damaged him by her rage. The hostile aim of this mechanism—the omnipotent control of the object—did not appear to be its major impetus.

The question arises, of course, whether further psycho-analysis, or analysis with a woman, or analysis wherein the transference resistance was handled differently, might have led to a more regressive situation with expression of rage and subsequent mastery of the primitive and aggressive 'mother transference'. The hypothesis favoured here is that the combination of an early but relatively isolated defect in her ego structure along with compensatory ego mechanisms of considerable integration and complexity with potential adaptive value predetermined the form of the assimilation process as it evolved during psycho-analysis.

Assimilation on Inner Reality

It is hardly necessary to state that a division of the assimilation process into topics of outer reality and inner reality is made for purposes of discussion. In actuality the assimilation process deals with both outer and inner reality, although

to a varying extent. The major aim of psychoanalytic interpretations is, of course, in large measure directed towards bringing 'inner reality' to awareness as a preliminary to the assimilation of its various facets. If someone is criticized—to return to the previous schema—assimilation in terms of inner reality deals with the significance of the criticism as it relates to various repressed conflicts; e.g. the criticism as it is felt to be a punishment for taboo wishes or the criticism as it gratifies masochistic needs.

The simultaneous experiencing and observing of the inner reality as a prerequisite for meaningful assimilation and subsequent reintegration has been emphasized by many authors (Bibring, 1954; Sterba, 1934). Yet even when this prerequisite is met, the assimilation process may still have a significant defensive aim.

Clearly, if any capacity for this type of assimilation is to exist, there must have been definite separation of the self from the object and also a relationship with a parent, whereby the parent has, at least at times, helped the child to master inner tension. Many questions come to mind. Is the potentiality for self-observation dependent largely on an identification with a parent who is self-observant? To what extent does the anlage for self-observation derive from a childhood situation where the parent actively indicates to the child that it is possible to recognize something unpleasant within oneself without losing love, prestige, and so forth? How far do compulsive defences aid or hinder this process? What is the optimum amount of stimulation from within that best fosters a potentiality for assimilation? Too much clearly overwhelms the ego and leads to primitive defence mechanisms which are incompatible with an ability for relatively autonomous self-observation. Too little stimulation—or too quick relief by one of the parents—is likely not to provide the impetus for looking inside oneself for the source of one's trouble.

At the same time that the child introjects a benevolent aspect of his parent and internalizes the mastery situation, he will internalize the more stressful struggles he is having with him. The parent uses words and ideas to help the child master his tension, but also uses words and ideas to scold or cajole the child to be good or to submit. The child similarly uses words and ideas not only in identification with his parent for mastery, but to fight back, evade, or outbargain his parent. The internalized form of this parent-child interaction, therefore, serves

both as the basis for superego and ego attacks and counterattacks as well as in less frenzied situations as the model for achieving mastery over forbidden impulses and for discovering appropriate outlets for instinctual gratifications. The adaptive aspects of this mechanism are based on the capacity to make complicated connexions, to discover the valid basis of one's feelings and actions, to view matters reasonably. Yet the superego is built into the process and at times of stress is apt to make its presence felt. At such times the ego may not just try to look at what is happening within the self for purposes of understanding, but may defend itself—the connexions made under such circumstances conceal as much as they reveal. Even after a relatively successful psycho-analysis during which the analysand has developed a capacity to examine in a meaningful way many aspects of himself, the use of such 'insight' for defensive purposes may be evident. This, of course, is all the more likely where childhood events have hampered the capacity to tolerate instinctual tension, where the fear of loss or attack is great and the anxiety mobilized by awareness of instinctual derivatives is massive.

The patient about to be described manifested increasingly as her analysis progressed a capacity and tendency to look at aspects of herself. Nonetheless, throughout, this awareness remained associated with anxiety, and she demonstrated a need either to reassure herself that she was not going to be attacked or to search ways to avoid, placate, fix up the environment if it should become hostile.

Case 2

This woman, a highly intelligent, successful person in intellectual spheres, entered psychoanalysis in her early 30s because of severe anxiety reactions and difficulties in her relationship with men. She had had, throughout her childhood, an intense relationship with her mother. The patient's intellectual activities were an expression of the more harmonious types of interaction she had had with both parents, particularly her mother. The beneficial aspect of her mother's keen interest in her, which did permit a primary type of separation, was offset by a strong tendency on the mother's part to dominate and control the patient. The mother showed an unhealthy and persistent interest in the patient's diet and toilet habits. She frequently used enemas and, as the patient reached

adolescence, was greatly concerned with and highly critical of the patient's sexual behaviour. The patient's father remained more or less in the background, although there was a period during which she was quite attached to him. As she grew older, she depreciated him, as did her mother, for his passivity and nourished a resentment that he had not been more helpful in her struggles with her mother. The patient had another intense relationship with an older brother who was her mother's favourite. Her early envy of him was repressed, and what she mainly felt for him for many years was a poignant loving attachment. The erotic aspects of her love for him were largely repressed, but the close tender feelings were marked and were first expressed as admiration for his achievements. This admiration was followed by an extreme solicitude when in his early manhood he ran into emotional difficulties. Her subsequent difficulties with men did not preclude intense sexual and loving relationships. However, despite several satisfactory offers of marriage, she became acutely anxious when the men persisted, and separated from her lovers with considerable depression. Her sadomasochistic orientation was very apparent. Usually she could not experience sexual satisfaction unless she had fantasies of being beaten by a man. Her masochism had been at the basis not only of her inability to get married but of several work experiences where she had sabotaged her success. While she was able to express anger, especially if she could consider herself abused, she was not able before psycho-analysis to recognize her own rivalry towards women, or her envy of men. When these feelings were mobilized, she found herself extremely panicky in the presence of 'unsympathetic' women or 'arrogant' men. Situations which aroused envy of men, anger at being rejected, urges to surrender either to men or women, or where she sensed any possible criticism of her sexual behaviour, were all dangerous. Despite her difficulties she was warm, likeable, and extremely effective in relatively non-conflictual relationships.

She openly expressed two fears at the onset of her analysis and actively tested out the analyst's attitudes that related to these fears. She was very concerned lest he force his ideas on her, and equally concerned lest he disapprove of her sexual behaviour. In view of the fact that previous therapy had foundered

because of these concerns, the implicit and at times explicit attitude was conveyed to her that, first, it was up to her to accept what she wanted from the analyst, and, second, that her own guilt about her sexual behaviour or about the impulses that were behind her actions was much more intense than any condemnation that her analyst could possibly feel towards her. The intensity of her anxiety on these scores was of a high level, and it was necessary to counter these anxieties, although in a considerably attenuated form, throughout analysis. The necessity to do this undoubtedly modified the quality of the therapeutic alliance, making it considerably less than the ideal 'scientific' transaction—to use Loewald's (1960) term—where the analyst and analysand together look at what is happening within the patient.

Nevertheless, the patient did develop, in a slow and somewhat tentative manner, a transference neurosis, and in the analytic situation she revived experiences and reactions to her mother, her brother and, to a less extent, her father. She was slowly able to accept the analyst's attitude that it was possible to admit sexual and envious feelings and urges without being condemned. Her fear of being forced also appeared to be counteracted by the analyst's permission to retain a freedom of choice as to how much of his interpretation she wanted to accept. These attitudes, which were benevolent relative to her mother's behaviour in similar situations, were internalized in a meaningful way. Examination of her own behaviour during stressful periods became more autonomous, less impinged upon by her conflicts about her guilt and her masochistic need to comply. Eventually she was able to recognize various factors of her masochistic conflicts. Both the pregenital and oedipal origins of the masochism became obvious in her dreams and daydreams, which she was increasingly freer in experiencing and examining. However, her eventual assimilation of her masochistic conflicts was derived from an understanding of the significance of various relatively diluted instinctive derivatives more than through a transference reaction, whereby massive clinging, sadistic or erotic impulses were directed towards the analyst. Perhaps because of this, situations which mobilized masochistic reactions continued to make her anxious despite a considerable diminution of the clinical manifestation of her anxiety.

At the end of her analysis she was aware of and able to tolerate many aspects of her urges to cling, of her sexual impulses, and of her sadism. This assimilation of inner reality, however, was contingent upon the simultaneous availability of evidence that the crucial external figures did not in reality threaten her. She could never fully accept her danger as internal, and she found it necessary while examining her own inner responses concomitantly to reappraise her situation *vis-à-vis* a dangerous person in a manner that suggested to her a way out of, or a method of coping with, the possible danger. At the time analysis terminated, she was aware of her wish to give in, to cling, to let herself be taken care of; she apparently could come close to recapturing the affective aspects of the wish; she could delay reacting under such circumstances in her former catastrophic fashion, where she became acutely anxious or employed relatively primitive methods of denial and projection. However, the connexions made during these times did not apparently lead to a thorough reintegration or reorganization of her view of herself and her milieu. She recognized her wish to cling, but was concerned lest the real people in the immediate stressful situation where this wish was actuated demand a surrender, and this interfered with her capacity to examine at that time the deeper sources of her urge. At such times she did indicate that she was aware that there was a relationship between her guilt over sexual and aggressive impulses and her need to give in, and that this was connected with her earlier struggles with her mother; but she was never able fully to appreciate and tolerate the intensity of those struggles.

Similarly, at the end of her analysis she was much clearer about the fact that when she saw herself ungratified she had very hostile fantasies. At this time her anxiety symptoms were much less acute and her need for masochistic fantasies to achieve sexual satisfaction had largely disappeared. She could experience direct sadistic fantasies, was aware that certain aspects of her behaviour were motivated by her hostility, and that she was hostile because in large measure she was frustrated. Yet these impulses were never fully tolerated, nor could she direct the major focus of her understanding towards the source of the needs that were being frustrated or towards what in her made her especially vulnerable to frustra-

ting situations. Of course, the analyst's interpretation had repeatedly attempted to make such links, and intellectually she was well aware of the genetic sources of her difficulties. At the times when she was angry, towards the close of her analysis, she no longer repressed, projected, or turned against herself the hostile impulse, and was aware of some of the inner conflicts related to the threatening situation. She did, however, find it necessary to reassure herself that the objects in her environment would not attack her, or, if she felt they might, to have a variety of methods to avoid, to placate, or to cope with them.

The effects of the introject of her critical and controlling mother and her fearful reaction to this introject—namely to surrender or to rebel—were too deeply rooted to be eradicated by the analytic technique, at least as employed in this instance. The more tolerant attitudes internalized in the course of the analysis were eventually to some degree autonomous and did permit a considerable delay which counteracted her more primitive reaction to the mobilization of instinctual impulses. The delay was followed by awareness and assimilation of various aspects of these impulses and marked alleviation of symptoms as well as by much more realistic and adaptive behaviour. Nonetheless the 'bad mother' imago was still there, and its presence still made itself felt by the patient's need, even at times when her capacity to assimilate was most autonomous, to reassure herself that she would not be forced to surrender to or to become involved in a hopeless battle with people who were external representatives of this imago.

In perhaps even more subtle ways, a rather thorough assimilation of one aspect of what was previously repressed may be utilized to minimize the threat arising from other aspects. In the course of a psycho-analysis, someone, previously very vulnerable to criticism by a colleague, will acquire the ability to look at and in one way or another assimilate his inner reality in situations where he feels himself criticized. He may become aware that he has intense competitive feelings towards his colleague, that he feels very guilty about his competitive urges, and recognizes that his hypersensitivity to criticism relates to his guilt. When he attempts, however, to assimilate what has happened, he may emphasize one portion or another of this inner reality. For example, he may focus on his

'magic thinking'—that is, while he is aware he has been hostile and that he has felt guilty about this, the central part of his awareness is directed towards his understanding and correcting primitive mode of cognition, that is, the all-or-none thinking which makes him so vulnerable to attack. This awareness has a reparative or defensive implication—if he has been using negative magic, if he had erroneously expected punishment for fantasies, neither he himself nor his environment is as destructive as he had thought. This mode of assimilation of his inner reality parallels the situations where the external reality is discovered to be not so dangerous as at first appeared. In both instances, the awareness may be valid relative to the previous appraisal, but both defend against the acceptance and tolerance of pain. In the present instance, the emphasis on and the correction of the 'magic thinking' will help to bolster the ego in its struggle with the superego and external reality and tend to obscure the presence of the id. The implication of his recognition is that there is no need to be so hard on himself, that 'thinking is not doing', that he is making too much of his own anger and his colleague's criticism, and that he is in no real danger from the attack.

This type of reassessment or assimilation may be useful and permit the expression of certain competitive actions. Yet it not only serves to deny the real possibility of retaliation from the colleague if he is actually aggressive, but more importantly it helps to repress his awareness of the extent of his conflict about oedipal wishes. In such a state he continues to be vulnerable both to the aspects of his superego which remain unconscious and to external threats which have the significance of attack.

In other circumstances, he may use awareness to help more directly in the repression of his id. For example, following his awareness and relative toleration of his hostility towards his colleague, he may recognize that he is reacting in an infantile, if familiar, manner, and that his reaction is inappropriate. The emphasis on the inappropriateness of his now recognized feelings has the implications that in reality there is no need to be so competitive and that there are plenty of medals and women to go round, that he is not locked in a life and death struggle. This once again is correct, and if he can, in fact, attune his behaviour to his evaluations of the situation, all kinds of benefits may accrue. In effect, he is telling himself to be reasonable; but the success of this kind of assimilation depends

upon whether it is his superego or a more autonomous portion of his ego which is advocating reasonableness. It is not such a great distance from the suggestion 'be reasonable' to the edict 'be good or you'll be hurt'. The more this process is instigated by the superego, the less likely is it that aggression will be under the control of the ego and the more his competitive impulses will be manifested in poorly integrated and unexpected ways.

The Nature of Relatively Autonomous Assimilation

The observing and assimilating ego can be at best only relatively autonomous. Elements of narcissistic gratification involved in the mastery of a threatening situation, elements of approval from the introjected parent on such occasions always to some extent permeate the assimilation process and contaminate its autonomy. The painful recognition of previously repressed conflicts, which is part of the process of assimilation, is usually rewarded by the lessening of the painful tension associated with unresolved instinctual conflicts. A process, where the individual using it knows or senses that its successful application will ultimately make him more comfortable, cannot be considered completely autonomous. That complete assimilation can at best be only approximated is based on the familiar observations, some of which have been elaborated in the preceding discussion, that insight is usually put to practical purposes—to restructure the view of a threatening outer milieu, to search for means of gratifying impulses, to defend in various ways against aspects of unconscious conflicts. There are, moreover, in my opinion only relatively few individuals who can achieve through psychoanalysis a capacity for approximately complete assimilation—individuals with unique genetic factors in their favour; even so, it is only under special conditions that these favoured people can make approximately complete and appropriate connexions. Up to this point the discussion has focused chiefly on the factors that interfere with the relative autonomy of the assimilation process. It seems in order to attempt to delineate the qualities and circumstances that are associated with a flowering of this autonomy.

People who have been psycho-analysed and who have developed a high capacity to observe and understand their inner reality have at their disposal an extensive number of techniques for this purpose and are able to shift from one

technique to another as the occasion demands. I have previously (Myerson, 1960) described an autobiographical fragment where the various steps involved in assimilating a stressful event were delineated. In this example, a recognition that I was overreacting to some as yet unrecognized source was followed by a deduction that I must have felt guilty over something I had done, and then by a recapturing of a previous mental state wherein I had both accused and defended myself for a minor act of omission. What was not accomplished at this time was the employment of free associations which most likely would have led to a clearer conviction of the unconscious roots of my behaviour. Complicated processes of this kind are a prerequisite for deep and meaningful assimilation. A high order of flexibility is essential for this purpose, whereby an appropriate type of cognition, re-experiencing, etc., can be mobilized in an integrated and orderly fashion and be directed towards understanding a wide variety of stressful situations. Unquestionably, different individuals have their own style for assimilation. A successfully analysed person with a compulsive character structure has different techniques available for assimilation from those of a well-analysed hysterical individual.

Somewhat discrete from the quality of flexibility, and yet related to it, is the capacity to assimilate the appropriate aspects of the self. Anyone, under stress, who feels impelled to recognize all the connexions of a conflictual situation is clearly using a compulsive mechanism to ward off the affect and significance of the crucial phase of the conflict. A selection of the appropriate aspect of oneself can only occur after a successful psycho-analysis where all the major conflicts have been worked through and are available for assimilation. A patient may be struggling at a particular time with intense competitive feelings. An outside observer, viewing the situation, may recognize that to some extent the competition defends against the patient's passivity. The patient, if successfully analysed, will be able to see this relationship; yet it may not be appropriate to focus on the defensive significance at this particular time; the charge belongs with the competitive conflict; right here and now, the patient's major difficulty—his anxiety, his depression, or his behaviour,—is caused by the activation of positive oedipal wishes. There are times, of course, when a selection cannot be made—when the person had rapidly vacillated prior to assimilation between

various libidinal positions and attempted one neurotic solution after another. On these occasions, it may be impossible to assimilate in a complete way the nature of such internal events, and the most appropriate thing to do is to suspend judgement until matters become more clear.

The recognition of the most appropriate aspect of conflictual events represents the 'foreground' of the assimilation process. When the process is fully developed, there is available in the 'background' or the periphery of awareness a sense of continuity between the crucial events and the most significant connexions. At such times there is an ability not only to link up cognitively meaningful connexions but to 'feel' that the present 'self' which is the most appropriate object of the assimilation process is very similar to past 'selves' where the same theme has been played, although in somewhat different keys. More than this, there is a sense of continuity between the different adaptive and defensive positions that have been taken to deal with several conflicts and between the various modes or states of mind whereby the various adaptive and neurotic solutions have been expressed, i.e. dream states, fantasy states, behavioural manifestations, etc.—it is the same person playing the various themes on one instrument. All this is appreciated in a non-judgemental state of mind which does not preclude a capacity to re-experience the affective components of the several selves. Judgemental attitudes will manifest themselves temporarily at times as the various selves are not only observed but re-experienced. Where the assimilation process is highly developed, this tendency to judge will be recognized as one expression of the many adaptive and defensive attempts made to deal with conflicts.

There are other ego functions, not in the usual sense cognitive, that become augmented by the psycho-analytic method, and whose concomitant utilization at times of stress is necessary for the employment of cognitive, assimilative processes. The structural changes effected by psycho-analysis involve more than an ability to look at and appropriately connect up elements from the self and non-self; improved methods for binding and discharging tension, which have been both preliminary and secondary to the development of new insights, are available at times of stress and allow the observing and assimilating ego to manoeuvre as it were in the efforts to evaluate and understand the threatening situation. For example, the expression of anger in graduated doses, activated by a pre-

conscious recognition that one is angry, may be necessary to alleviate the economic conditions which otherwise would inhibit the ability to examine the nature of the angry situation. Similarly, an ability to bind tension and delay discharge, structural changes effected by a successful psycho-analysis, are prerequisite for assimilation. There are several orders of delay which in general parallel broader and more meaningful types of assimilation. At the very least, for any type of looking at threatening situations to occur, the ego must have measures to tolerate anxiety and instinctual tension and to delay the utilization of infantile defences. Furthermore, assimilation of any real meaning is contingent upon a capacity to tolerate the significance of what is observed and to delay immediate efforts to find solutions—e.g. to avoid the threatening situation, to search for tension-relieving methods of gratification, etc. In its most highly developed form, the process is compatible with a toleration of the fact that tension will always exist—there is no nirvana in life, that reality offers limited means of gratification, and that the ego, even when the process of assimilation is most effective, can only partially counteract the repetitive compulsion of infantile

conflicts. There is the ability to delay writing Q.E.D. at the end of the assimilation process.

Toleration not only means a willingness to face something unpleasant over and over again, but *an ability and impetus to look for new, deeper, still more painful insights*. In this sense it is part of an urge to grow which reflects a very special kind of relationship with one's parents, further reinforced during the psycho-analysis itself. There is inevitably both some pleasure and some suffering in the process of toleration. The pleasure comes from the sense of mastery, in part derived from narcissistic and approval-seeking needs. There is a similar type of suffering in childhood when there is a willingness to suffer some pain in order to grow. In severe disturbances of the parent-child relationship, where the suffering, approval-seeking, or narcissistic gratifications become ends in themselves, the motive for growth loses its autonomy. The process of toleration must be relatively independent of masochistic, narcissistic, and approval needs for the most meaningful growth to occur. The individual who tolerates painful insights in a meaningful way revives the harmonious situations in his childhood where his parents were pleased by his becoming truly independent.

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THE NON-VERBAL RELATIONSHIP IN PSYCHO-ANALYTIC TREATMENT¹

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At first it seems paradoxical to talk of the non-verbal relationship in psycho-analytic treatment when classical analytic technique rests entirely on the dialogue between analyst and patient. The relationship established between them, which is at some times the very substance and at others the activating force in the therapeutic procedure, can only be clarified and interpreted by the use of words.

It would certainly be absurd, therefore, to deny the importance of words in the analytic relationship. By the use of words the patient makes himself known to the *other*, the analyst, and thereby learns to know himself too; he learns to express his desires and his fears; he assesses what he thinks he possesses and what he lacks—what he is and what he would like to be. But talking in analysis is even more than this, as we know—it is a continuous search, a veiled demand to be listened to, reassured, understood—in brief, to be recognized as a person and to be loved.

We also know that this demand, which cannot be fully satisfied in the analytic situation, will lead the patient through the vicissitudes of the treatment process to the end when he leaves the analysis and the analyst to look for a more satisfying object in an outside world which has at last become real to him.

It seems unnecessary to linger on the subject of the fluctuations which occur as the analysis progresses and which every analyst knows well. Throughout the treatment we see words used by the patient not only to express his thoughts and to reveal himself, but to appease, seduce, and disarm the analyst as object—particularly when the latter is unconsciously feared.

We recognize then that words are the vehicle of all the affects underlying the analytic relationship. And it is just because they express or provoke these affects that certain words take on particular values at different moments during

the course of treatment. For instance, I remember a cyclothymic patient I had in treatment for a long time, whose progress was slow and painful, until the moment when in showing her (as I had indeed already showed her many times) the restricting power of her oedipal fears, I spoke of her fear of being a *usurper*. This word, no doubt crystallizing a great deal of preparatory work, seemed to release a trigger in her. It was as if a veil had been torn apart. And so it was that the real liberating process began which proved decisive.

I should however like to draw the reader's attention to another aspect of the role of speech in psycho-analytic treatment. We have just seen how speech establishes an essential bond between patient and therapist. Now it follows that if speech can form such a link between patient and therapist it is also possible, in the patient's unconscious, for it to become a barrier profoundly *separating* them.

In analytic dialogue the patient talking to the therapist as *object* well knows that in this relationship between two the object is separated, distinct from him, and that the words addressed to the *other* can only confirm a separation which, for the unconscious, is painful. For the human being—so it appears to me more and more clearly—harbours two fundamental and contradictory aspirations: one towards separation (perceived at the time as a kind of liberation) and the other towards complete and absolute union.

In the analytic relationship the patient expresses in different ways, through the transference, his need to be understood, accepted, loved by the *other*; but separation is nevertheless experienced by him as a natural fact, rationally accepted. However, in spite of himself, something at the deepest level inside him *refuses* separation and strives blindly towards a union in which subject and object would be no longer

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distinct but *one*. The patient cannot, however, express this wish for two reasons: firstly because he does not recognize it, and secondly because this need for union, or shall we say *fusion*, plunges him down to a level in his development at which speech has not meaning and language is as yet unknown. The subject has to reach the object-relations level—and it is precisely at this turning-point in development that he feels himself separate from the object—before language, and at the same time the functions of the ego, begin to appear.

The ego acts, we know, as a controlling agent, as a superintendent, and as a filter for demands coming both from external reality and from internal, unconscious reality. The ego confirms this separation as if it marked the frontier between the internal and external worlds. We also know that these ego functions can be exercised too strongly, and the ego (a term which I have always thought too anthropomorphic) then becomes tyrannical and entirely inundates mental life.

When the infant reaches the object-relations stage and feels himself separated from the object, he then has only one means of reaching this object, of trying to possess it, and that is language; language which indeed at that stage is not more than rudimentary, as little developed as the other motor functions by reason of the immaturity of the nervous system.

What is the meaning of speech, and to whom are the first inarticulate babblings addressed if not to the mother—to this object from which the child feels himself separate but tries to find once more? For it is man's nature to try to separate himself, to free himself from the object on whom he depends, in order to open out on his own and at the same time to try to reach and hold once more the object from which he has separated himself. These two drives, apparently contradictory, are found in exactly the same way in the analytic situation. At least this is the view I have many times put forward.

Accession to a world resting on this subject-object duality has the fatal implication for man of *separation*. This external world gives rise to needs and wishes which are nothing but an illusory pursuit of the sole object, in various guises. Nothing can satisfy the subject except the possession which can wipe out separation. That is why the world of external reality—that of separation—gives rise to a throbbing need to *have*, to possess—a need which the world of multiplicity can only reinforce but never satisfy.

For what the subject wants is far beyond that multiplicity: he could only find peace in a union with the object so complete that it would imply a *fusion*. Freed, by this union, from the need to *have*, the subject would spread his wings in the sole joy of *being*.

How is this fundamental need for union manifested during the course of analysis? Precisely when the flow of words ceases, giving way to silence, to a silence experienced in security, in tranquillity. Experience has shown me many times that the patient in the midst of this silence finds again at times an internal state of union with the object-analyst, through which he again reaches in the innermost depths of his unconscious the original where the subject-object duality is no more. It sometimes happens that he reaches a point where indeed he feels himself at one with the world and as if con-founded with a wholeness in which the limitations inherent in the human condition become wiped out. He then wants nothing more, pursues nothing more, but experiences the intense joy of being.

If readers see here only metaphysical speculations, foreign to psycho-analysis proper, I should like to quote something that one of my patients, who knew nothing of metaphysics, said one day. After a silence lasting for the greater part of a session he said 'I have not talked today—I was giving myself up, in this silence, to something extremely good, healing, as if I had plunged into a deliciously warm bath. To feel that you were there, in this silence gave me a wonderful sense of well-being.' The symbolism of the warm bath and the delight in the silence do not, I think, need explanation. But beyond this unconscious return to the maternal bosom there appeared to me another, more important meaning—that of the return to an original state of union—absolute and without restriction.

Another of my patients, after a long, perfectly calm silence at the beginning of a session, looked at the sky through the window in front of her and said, 'I feel so blissful in this silence . . . as if I were united with the sky and the sun, melted into the Cosmos.' Obviously these are just images, but the choice of these images is in itself symbolic. If certain deep truths are not accessible to us except in the guise of symbols, I am tempted to believe that firstly this is because the symbolized truths are sometimes of a kind difficult to express, and secondly—perhaps this is the most important reason—because these truths, expressed in this way, are less frightening

to us. The chosen symbol itself is a representation familiar to the human mind—an image which brings the mind back to what is known; whereas the truth can never be perceived in its entirety: some part of it is always submerged in the unknown. It is in fact the non-verbal relationship which takes this indefinable part into account. That is why the necessary condition for it to arise is that fear be first overcome and eliminated from the mind. It is this point in particular that I would like to stress here.

Anyone who is frightened cannot bear silence. Because of this, the non-verbal relationship is not always possible in any analysis, and particularly not at any particular moment in an analysis. Besides, is it possible to talk about a non-verbal *relationship*? Does not this term 'relationship' rather imply the use of language, arising from the separation of subject and object and the attempt to remedy this separation? What we are rather incorrectly calling 'non-verbal relationship' is the establishment of the person on a level at which there is no separation: therefore no two-person *relationship*, but a *union*. The subject-object duality is wiped out, dissolved into a whole in which there are no more distinctions.

Among all the well-known motivations for the sexual act (over-determined like most human behaviour) there is also included the need to abolish separation in union. We read in Genesis: 'They shall be one flesh'; and human love, when it goes beyond the sole need to possess the object, is directed towards a complete union, to that ideal fusion which alone can fully satisfy it. That is why union can only be communion. It excludes 'relationship' in the true sense, that which implies a kind of bridge thrown between subject and object; that is to say, a communication which maintains the separation between subject and object as such.

The communication necessary for a relationship is established by the use of language. But it is by silence and in silence that a two-person relationship can dissolve into communion. I am using the word 'communion' here in the sense in which Kelman (1958, 1959, 1960) uses it. However, if I appreciate some of Kelman's ideas on this subject I must say that I find it difficult to follow him in the conclusions that he draws from his clinical experience. In fact I find the constant presence of fear, or the shadow of fear, in the situations he describes. Now fear seems strictly to exclude any possibility of achieving the state of union which he calls communion.

For silence to be beneficial it must be made tolerable to the patient; in fact he can bear silence only if he feels perfectly at ease in the analytic situation; that is to say, if fear and tension have been eliminated or at least attenuated. This tranquillity is not possible for the patient unless the analyst by his own deep inner attitude—and not only by the words he utters—reassures him and protects him against fear in order to give him the opportunity himself to eliminate fear little by little. It is this deep inner attitude on the part of the analyst which in fact can only be revealed to the patient in silence and gives the silence a fullness and a therapeutic impact. It is in this sense that I take up again the term 'non-verbal relationship' which now seems more explicit.

Some authors have indeed already studied the non-verbal relationship. But so far as I know, they have thought of it particularly in its negative aspect: in short, what the patient cannot express in words he translates into gestures, play-acting and general bodily attitudes, etc. (Greenson, 1961). Others have centred the problem of the non-verbal relationship on silence—silence which to them means either an inability on the patient's part to give way to a discharge of an affective or emotional tension (Loewenstein *et al.*, 1961) or the fear of expressing transference manifestations (Glover, 1955). Did not Freud himself consider silence to be a first resistance to the transference? Silence is moreover usually understood as resistance, and is interpreted as such in the analytic relationship ('passive-masochistic attitude'—Glover, 1955).

Finally, when I sent a résumé of this paper to Dr Kemper (necessary for the preparation of the Congress) he had the kindness to inform me that he had himself published (1948) an article dealing precisely with the problem of silence in the analytic relationship. In that article he distinguishes first the kind of silence which consists in 'dropping into silence', and then the kind of silence that is consciously motivated and the silence which is unconsciously motivated. This last kind of silence would betray in early stages, amongst other processes, the fear of contact, unless it is the disappointing nature of the contact with the analyst.

But the most interesting part of Kemper's article has very much the same perspective as my own, namely the 'productive' character of some forms of silence. Through the transference the patient can, by silence, make a step forward in his development, in the sense that his silence is a

way of measuring himself against the analyst and of challenging him, even if it is still only a frightened way of doing so, somewhat as a child would stand up to an adult.

The technical implication of all this is summed up in the questions Kemper asks himself when confronted with a patient, and which seem important: how is he silent, why is he silent, and above all why precisely *at this moment*, that is to say, at such and such a point in the treatment?

Ever since I have understood the therapeutic importance of the non-verbal relationship I have been careful not to take all silences up immediately nor to interpret them systematically as manifestations of resistance during the course of treatment, as classical theory would have it. When a patient does not talk I do not in any way incite him to do so. If he says 'I have nothing to say' or 'I do not want to talk,' I reply simply 'All right, don't talk'. It is understood that for the silence to be fruitful not only the patient, but the analyst also, must be able to bear it perfectly calmly—that is to say, without unconscious fear. If the therapist finds he has a need to light a cigarette at the precise moment, for example, or to wind his watch, or to cough, or make some such movement, he will be betraying a certain lack of ease brought about by a kind of fear which the patient perceives intuitively. Union—or communion—is not possible then, since between the subject and the object stands an insidious fear. The object is not then perceived by the subject merely as distinct, separate, but even more as dangerous, being himself overcome by uneasiness.

For the patient to be able to let himself go in that special kind of deep union which he unconsciously desires, it is more than ever necessary for the analyst to bring a certain *quality of presence* rooted in inner availability and openness. This quality can only be beneficial if it arises from an authentic inner attitude; any semblance of it would be without value, without bearing, and without significance. What significance would such an attitude have, and what would be its efficacy, if it were not based on a truly profound interest on the part of the doctor for his patient, a constant and unconditional understanding?

I must add here, however, that this gratifying attitude cannot be adopted directly in an analysis: it could be not only useless but even constitute a risk to the satisfactory progress of treatment as long as the patient's aggression has not been reduced; because aggression implies

guilt, and as long as the patient is unconsciously full of guilt he cannot accept from the analyst an attitude felt as gratifying without his guilt being aggravated. This would lead to his becoming more aggressive as a defensive reaction, and then to his feeling more guilty, and there would then be a serious risk of his becoming involved in an unshakeable transference neurosis with its implication of interminable analysis.

That is why I still consider the classical attitude of neutrality to be useful during certain phases of treatment, the phases in which a climate of frustration skilfully administered is necessary for the development of the transference neurosis. It must be borne in mind, however, that the transference neurosis should be only a stage in the course of treatment. If this stage is too prolonged and becomes fixed, it will then become incapable of resolution, since then the patient is settled into a sado-masochistic relationship which is a repetition of the pathogenic relationships of his childhood—that is, the infantile neurosis. A new illness, as Freud said, has then replaced the old one.

If I remind the reader of all these ideas which are certainly familiar to him, it is so that I can add here that if we wish to avoid the serious mishap of an irreducible transference neurosis there is a moment in the analysis when it is necessary to avoid a rigid conception of neutrality. Without ever falling into the still more dangerous hazard of gratifying the patient with affectionate words or gestures, it is however necessary for the analyst to have a different *presence* in the analytic situation, maintained by this deep understanding attitude; I would even say an attitude of authentic benevolence. I have advocated this particular 'presence' on the part of the analyst for a long time past (in fact since 1949).

It is only this other quality on the part of the analyst which allows the patient to find, in silence and tranquillity, this special state of union to which he aspires. It permits him to renounce the myth into which he had put the therapist and to strip him of all the fantasies he had about him, particularly the aggressive fantasies, charged with fear. It is only when the analyst has ceased to be a terrifying object that a non-verbal relationship can be established in security—one in which this kind of 'union' so much desired can be arrived at.

In the paper that I was asked to present at the Edinburgh Congress (1961) on curative factors

I insisted above all on the fact that the curative factors so often cited, such as the modification of the superego, the reinforcement and strengthening of the ego, and even the necessary gradual insight into unconscious processes, cannot lead to an effective cure unless the deep inner attitude of the analyst is as it should be. For if what the analyst says, the interpretations that he gives, are to be of value to his patient, it is rather in what the patient unconsciously perceives from the unconscious of his therapist that he finds—or does not find—the source of security he is looking for. The words of the analyst and the interventions that he makes are only effective in so far as they open up a path to the patient. But the latter cannot set himself upon that path, follow it, and finally emerge from it, unless he feels himself secure in the non-verbal unconscious to unconscious relationship. That, I feel, is the key to happy progress in analysis. That is why it does not seem desirable to preserve the rule of neutrality rigidly throughout the treatment, without taking into account the stages in its development.

The transference neurosis in my opinion should be present only at the culminating stage in the analytic process, and should last as short a time as possible if the treatment is not to become bogged down in a hopeless labyrinth. If this danger, which amounts to a failure, is to be avoided, it seems necessary at the appropriate moment gradually to replace the classical neutral attitude by one which I shall describe as a *gratifying presence*, in which the patient perceives a deep-down attitude of availability and hearty attentiveness. In such a climate it is sometimes sufficient to give a word of encouragement underlining a progress accomplished, or even a simple acceptance of a requested change of times, or yet a prolonging of the session, be it only for a few minutes, so that these gratifications can take on the significance of a 'gift'. Thus a new relationship is instituted: from now on the object—in this situation the analyst—ceases to be feared, and the subject can at last allow to be revealed in himself this fundamental need for union which leads all men to rediscover, beyond any love object, the original source of all life.

If the non-verbal relationship which I am attempting to describe does not come about, if the process of treatment extends only to the bringing of unconscious material to consciousness (in my view, a limited approach to the unconscious, at all events in one essential

direction), the instinctual forces will certainly be better used by the patient to adapt himself to everyday life; but he will remain deprived of a world of great richness which is spread out on a less generally known side of the unconscious. To limit the unconscious to instinctual drives alone seems to impoverish it a great deal. It seems necessary to find in it a complementary dimension, to reach back further to certain sources of life itself, born not in the tumult of the instincts, but according to Huxley's image, in 'the peace of the depths' where a whole part of the mind lies immersed.

In this way we are led to distinguish two very different functions in an analysis which proposes to establish the patient in the fullness of his potentialities: the first would be the attempt, by methods familiar to us, to reinforce the ego by bringing instinctual forces to awareness. This reinforcement leads, as we know, to a better and more harmonious adaptation to the external reality of the world of the senses, and this permits the patient to benefit more from the outside world. The second function would be to open up, by an extremely quiet communication, the access to another part of the unconscious which anchors man in a permanence which escapes the continuous ebb and flow of multiplicity, the troubles of history and social conditions. In this way man can arrive at a complementary dimension of knowledge—an approach similar to the 'Noein' of Parmenides, transcending the 'reasoning reason' which cannot escape the subject-object duality.

The question is by no means to encourage the subject to establish mainly a type of non-verbal relationship during the treatment, for he would then run the risk of sinking into a regressive unsatisfactory relationship. I have already made a preliminary formulation of these ideas in an article entitled 'Du monde pré-objectal dans la relation transférentielle' (1959). I pointed out in that article the danger of allowing a patient to become fixed in this so-called union, in such a way that the analyst may not be able to free him from it. If we can arrive at and tolerate in the analytic situation this profoundly peaceful silence in which a non-verbal relationship is established (satisfying an essential need in the patient, as I see it) we must nevertheless not allow the patient to become fixed in a regression so delectable to him that it prevents his making a healthy adaptation to reality. In my view the establishment of this non-verbal relationship ought to mark certain important points in the

analysis, just like the transference neurosis at its strongest, but both present the same hazards if we allow the patient to indulge in them indefinitely.

It must be emphasized again how important it is for the patient to be able to experience this desire for union in a profound quiet—a desire for an *impersonal* union, as it were, extending at least beyond the person of the analyst. At the same time the analyst must be on his guard against this being an enriching experience which never becomes a kind of relationship, to which the patient attaches himself too firmly. Because in fact nothing ought to turn the patient away from the world of reality, in which he must learn to live as full a life as possible. That is why, if the deep inner attitude of the analyst can permit the patient to reach this silent region and to enjoy there the satisfaction of a kind of fusion, to which he unconsciously aspires, this attitude must also enable the analyst to control it in such a way that it can bring the patient back to

external reality and thus underline the *necessity for separation* implied in all object life. In short, once fear has been liquidated and ego functions reinforced it is a matter of allowing the patient to become aware of other sorts of need which are situated at a level other than that of the instinctual forces; at the same time carefully emphasizing the still greater importance of making a necessary adaptation to everyday life. What is more, this procedure can only bring about an increase of richness. Only certain fears, generally not recognized but none the less powerful, lead a man to believe that different aspirations are contradictory and irreconcilable, driving him to cut himself off from this one or that. If the analysis can help him first to recognize these aspirations and then to accept them in their various kinds, without being torn apart by illusory contradictions, he will reach a quality of fullness which is certainly the most worthy aim that psycho-analytic treatment can set itself.

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THE FRAGMENTIZING FUNCTION OF THE EGO IN THE ANALYTIC SESSION¹

By

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In a recently published paper (Peto, 1961) I put forward the hypothesis that there is an ego function which aims at the extreme splintering of the dynamic complexes of drives, of object representations, and of the emotions and feelings permanently or loosely connected with them. This function precedes and accompanies all the known defence mechanisms (repression, identification, etc.), and complex defence measures, e.g. splitting, sublimations, and is indeed, I believe, the necessary precondition which makes them possible. It prepares those changes in the nature of mental energy which have been variously called desexualization, neutralization, deaggressivization. I called this function the ego's fragmentizing function.

The above considerations make it clear that a sharp distinction should be made between splitting-off, e.g. as described by Freud in the fetishist, and the fragmentations which may cause the splintering of mental representations. My assumption is that only the latter is caused by the ego's fragmentizing function.

I discussed very briefly the possibilities of this ego function's role in dream dynamics, in children's play, and in the effects of interpretations. I pointed out its relation to regression, isolation, and to the superego's functioning and development. I also attempted to demonstrate its presence in transference neurosis. A masochist's transient somatic symbolization process (hypochondriac 'cancers' and 'heart attacks') in the course of his transference neurosis offered an opportunity to discern the operation of fragmentizing on the symbolic, somatic representation of a threatening, bisexual mother image. The dynamics indicated that the patient's ego was splintering some dangerous aspects of his archaic superego. This process freed energy for

sublimation and for a less threatening object choice. It also preceded a more successful repression of the 'bad' mother image.

The bad heart, the 'heart attacks', acted as substitute for the cancer. The fragmentation of this symbolic somatic representation of the mother image was even more obvious than that of the 'cancers'. During the sessions with the rise and fall of the 'badness' projected on to me, there was a rise and fall in the number and strength of the palpitations, of the radiating pain, and of the attacks themselves. The accompanying anxiety signals oscillated in a similar way. This fragmentation of the archaic mother image gradually gained the upper hand; the attacks subsided to a great extent.

Illustrative Session

The oscillatory interplay of projection-introjection concerning the image of the analyst, the patient's self and the archaic parental images, can be understood in greater detail if we accept the concept of the ego's fragmentizing function. I shall attempt to show in the dynamics of a single session with a neurotic patient that during important phases of the transference neurosis the analyst represents from the beginning of the session a stimulus which is in many respects similar to the function of the day's residue in dreams. The process of projection-introjection proceeds in such a way that not whole object representations (those of the analyst, the patient's self, and the parental images) nor even parts of them are subject to these defences, but that even in the course of a single session a splintering of parental images and of the analyst as an object occurs. The smallest traits merge and fuse, separating and re-

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imposing themselves. This may bring about bizarre and ephemeral combinations of images and feelings and relationships. The ensuing mosaic is not the replica but a combination of archaic traits and contemporary analyst qualities. Only after these preparatory transitory phases of extreme purposive fragmentizing have passed, does the picture emerge of a more consistent, more meaningful, and longer lasting result of projective and introjective defences. These finally lead to more mature identifications and sublimations in the patient.

My assumption is that these dynamics occur in the transference with every patient, irrespective of the gravity of the neurotic or psychotic disturbance.

This session took place early in the fourth year of the patient's analysis. The patient was single, male, and 30 years old at that time. He entered analysis because of difficulties in his heterosexual life. He often suffered from premature ejaculation; furthermore, he never found emotional gratification in his love affairs. There were also difficulties in his job; he often clashed with superiors and equals. An additional problem and worry was his conscious homosexual interest in young boys from 8 to 12 years old. This trend was channelled through participation in boy scout and similar activities and found physical gratification in wrestling and romping around with young boys.

The mood of the hour was determined by the patient's prospective vacation with his parents. This event had been contemplated for a long time, and was highly charged with ambivalence in reality as well as in the transference. He was grateful that I did not forbid it; but, as a matter of course, he also deeply resented that I let him go, thus demonstrating, in his opinion, that I did not care about his liberation from his parents' yoke.

I shall report several phases of this session. They marked the phases of most conspicuous fragmentation. The sole aim of this paper is to demonstrate the operation of the ego's fragmentizing function within the frame of a single session. The analyst did not interpret the new aspects of resistance or content in the material, since this session was in sharp contrast to a foregoing period of sustained massive resistance. It seemed at this session that new avenues of the transference were opening up, and this surmise proved to be

true. One of the main trends during the session was an attempt at liberation from various superego pressures which were in operation and which represented different phases of development.

(i) After bitter attacks against his father's and the analyst's 'inconsistencies', which played an important role in his transference neurosis, he began talking about his parents' desire to see him happily attached to a girl. However, his feeling was that his parents condemned his sexual life in general and his close attachment in particular since then they would lose him. (This aspect of his castration fear and his guilt had been extensively discussed in the past without having been worked through satisfactorily.) He thought that I would, as his analyst, officially want him to fall in love with a girl, but nevertheless was convinced that somehow I wanted to keep him for myself.

I wanted him to fall in love because I was afraid of my own homosexual trends. Actually he felt disappointed that I agreed to his vacation with his parents. He was sure that I did not want him to go, and that I was jealous of his father. This led to a discussion of his mother's feelings towards him. She desired to keep him under her bitter-sweet control despite all her overt attitudes to the contrary.

Here several aspects of the mother image were fragmented and discussed in their elements:

- mother's 'female' jealousy
- 'bossiness'
- seduction
- protective attitude
- wanting to be protected
- hostilities of different types.

(ii) This led him to refer to similar characteristics in him in relationship to his father which, in his opinion, made his mother jealous and excluded her, in a way, from the father-son relationship.

These were:

- patient's boyish attractiveness
- his homosexuality
- his anal relationship to his father.

Thus several elements of the mother image and constituents of the femininity and of the pregenitality of his self image were fragmented into their constituent representatives, though the elements indicated were themselves

built of even smaller units. They were then projected onto the analyst.

He entered into a discussion of the analyst's manifold supposed identities with him, his conviction that I struggled with the same problems as he did, and he referred to some of them, such as my supposed excitement whenever he talked about his homosexuality, etc. These supposed traits of the analyst were subject to fragmentations and subsequent introjection.

(iii) They enhanced, after integration, his bisexuality, as was proved by the immediately following report of a dream from the previous night. In other words, the described dynamics triggered the taking up of the dream at *this* phase of the session. It is obvious that the dream and the sessions represented a whole stream of dynamics exerting their pressure in the transference neurosis.

The dream was as follows: There is a young boy, maybe the patient, with an invisible head, shrouded in a kind of cloud. His torso is bulging as if he were pregnant. He admires his protruding stomach.

The following associations and transference waves were clustered round three main manifest elements: the invisible head, the protruding stomach, and finally the sex of the patient in the dream. These three elements of the manifest dream led to three distinct latent thought groups which represented complex partial conflicts. The latter were subject in the course of the projection-introjection process to fragmentations and subsequent integrations in the course of the session. I shall discuss them separately according to the appearance of the main oscillations of the transference dynamics.

(iv) The patient started associating, at his own choice, to the bulging stomach of the young boy. The first associations brought to the fore feminine fragments in the line of the obvious mother identifications with partially general, partially historically determined representations, including pregnancy fantasies and thoughts about bisexually formed genitals. This led to a distinct event of his life when at the age of 8 he was dancing naked in front of his admiring parents. He saw himself, slim, stomach boldly protruding, his little penis swinging between his legs, swirling and turning, showing his buttocks to them. He went on to praise young buttocks which are so similar in young boys and girls. He talked of

his attraction to young boys, his desire to watch them for hours, and his intense pleasure in touching them surreptitiously while romping around with them.

Here fragmentizing preceded and accompanied manifold displacements and cathexis-shiftings between images of the self and of his parents, accompanied by drive oscillations, mainly in the sphere of exhibitionism-scopophilia representations and complex bisexual conflicts.

After this detailed fragmentizing of some important aspects of his self, and of the parental images, he projected them onto the analyst, who became in this way identical with the patient's and his parents' qualities and desires, as discussed above. He subjected my traits to a detailed examination in the same area in which he had previously dealt with his parents.

(v) The fragmentation of the analyst's image led to a renewed introjection of this figure and its integration into the father image of the patient. He started talking in a similar vein and in detail about his father's supposedly homosexual traits and his involvement with him. This additional strengthening of the self led to a new aspect of the bulging stomach in the manifest dream. The previous multiple fragmentations paved the way for a cluster of masculine representations, the fragments being drawn from the patient's self image, the father's and the analyst's image.

A rather chaotic group of thought and feeling fragments appeared: father elements, like a large body, strength, father's large penis watched by the little boy; fragments about a present-day friendship with a man who was the representative of both strong masculinity and open homosexuality towards young boys. Emerging was the image of a large penis belonging to the father, then developing on the growing young boy, who was vying with his father for his mother's love and admiration. Here fragmentizing preceded and accompanied regressions in thinking and in ego-strivings. These formal and temporal regressive changes carried with them simultaneous pregenital drive representations. Out of these dynamics emerged an integration of the self image to the phallic level.

(vi) Under pressure of increasing guilt, this image was again subject to fragmentation and then projected onto the analyst, who became a powerful father representative, threatening the

patient homosexually with his desires as well as with his interpretations. Here again several references to the analyst's hostile qualities and aggressive traits followed.

After this fragmentation of the father-analyst representation, this image was introduced by the patient. The emerging integrated image was cathected mainly by shifting of the drive representations to manifest homosexual desires. A well-defined homosexual self emerged.

(vii) He developed a fantasy: he was lying motionless and enraptured on a young boy 'doing nothing to him'. This state was disrupted by a new flow of associations in the course of which the analyst-figure was subject to extreme fragmentation into bisexual father and mother elements, into wooing and seducing and aggressive attitudes. The patient oscillated between good and bad self-representations as well, between seduction and destruction in a succession of hetero- and homosexual cravings.

(viii) The session was nearing its end, and the patient's sense of time helped him to overcome these oscillations of fragmentation and integration which were, as a matter of course, precipitated and conquered through constant signals of castration anxiety and guilt. These oscillations eventually led to a rational and realistic assessment of the patient-analyst relationship and an ability to express in social and sublimated terms what occurred in archaic and regressive forms during the session. He mentioned that one of the corporations' senior executives had met him in the corridor and told him that his skill in dealing with clients and his ability to adapt himself to the frame of the organization had improved substantially in the course of the last year. He was able to feel and think of himself and of the analyst in terms of contemporary reality. This brought about a transient relief from anxieties and he was able to express gratitude. He was also able to sublimate the patient-analyst relationship into its social contents and functions.

Discussion

I chose this session because of the clear-cut oscillations, because abundant material had been worked through in the previous three-and-a-half years, and finally because there was a free flow of thoughts and emotions. It is easily discernible that apart from the discussed

turning points, there are several others present which then led to identifications and projections. To discuss all of them would lead to an even more complicated rendering of the trends presented.

I assume that my discussion so far has clearly indicated the meaning of the concept 'fragments'. I try to describe by this word those ego units which are clinically discernible and which carry with them a certain representation of affect signalling, furthermore, a general feeling, and in addition the mood in which they may have been historically coalesced into a part-image. They represent some particular aspect of the self, and thus consist of ego, superego, and drive elements.

The flow of the primary processes in the session displays the operation of highly dynamic fragment representations, which at the same time precipitate other fragments to act and interact with the image of the therapist. In the stream of the primary processes distinct features can be recognized. There appear historically determined representations, but they are always preceded and accompanied by smaller fragments of the same complex.

The concept of primary process functioning implies, among other things, the operation of prelogical, archaic symbolism; therefore the words spoken in such a state by the patient are identical with the things they symbolized. Thus when we encounter thought and feeling fragments in the course of the session, we are dealing, from the point of view of the unconscious, with fragments of the real things and relationships they represent. These fragments often represent much smaller units than we would consider part-object representations. A more coherent picture of events and things and relationships appears only after these fragments become loosely or more consistently built into a more meaningful part representation. In climactic sessions, after each completed fragmentation and integration into a coherent ego unit is temporarily achieved, subsequent new fragmentations appear which represent some other aspect of the very same or related thing or relationship. This then again becomes integrated, and so the process goes on. This operation is more or less discernible in its clinical appearance.

The presented view explicitly states that the ego is constantly gaining strength from these fragmentations. The dreamwork and the often amazing partial integrative ability of the acutely schizophrenic personality prove, among other experiences, that fragmentation does not neces-

sarily imply the complete breakdown of integration. It explains the fact that ecstatic states may go hand in hand with high creativity in the artistic and to some extent even in the intellectual sphere.

One of Freud's important principles states his view on the nature of thinking. It is to be found in many passages, one of the clearest in the book on Jokes (1905). 'Ideation or "thinking" differs from acting or performing above all in the fact that it displaces far smaller cathectic energies and holds back the main expenditures from discharge.'

Freud refers to 'smaller cathectic energies'; I would suggest that this reduction of energy cathexis may come about in one of its phases through the fragmentation of mental representations. These then individually represent a smaller impact, since only a partial historical or contemporary aspect of the traumatic representation is cathected by the ego. This provokes subsequently less stress and less anxiety. (Many other facets of this complex process under normal conditions were discussed by Freud in his works on dreams and jokes.) Thus the ego is able to refrain from a complex high energy discharge, and may react only in proportion to the fragment (of an image, of drive, of feeling) which is in the centre of the ego's attention. An additional advantage may be that the displacement and de-instinctualization of this fragmentary representation may develop more easily, and so may pave the way for initiating sublimations and other ways of dealing with hitherto repressed representations. The ego apparently has to go through these phases of fragmentation to build up new small-scale adaptive integrations while dealing with external and internal reality.

The view discussed on fragmentizing in the course of the primary processes stresses its 'purposefulness' in the sense that Freud applied this concept in Chapter VII. The clinical observations and assumptions cited have their counterpart in similar physiological mechanisms, which

maintain the dynamic biochemical balance of the body, e.g. blood-sugar level, electrolytes, etc. These are kept on their normal level through equilibrium of breaking down and synthesis of the compounds. This catabolic-anabolic equilibrium may have its parallel in mental functioning.

I have attempted to show that, in the analytic session, phases of fragmentizing may develop into an anticlimactic integration, which then leads to another phase of fragmentation of the similar or somehow related subsequent part element. I am inclined to assume that a transference interpretation is successful if it is given at the moment when the switch from fragmentation to integration or after complete integration to the next fragmentation is implemented by the ego. Such an interpretation, through its timing, has the double effect of (i) helping the integration through the patient's introjection of the analyst as represented through the interpretation; and (ii) the very same interpretation having a traumatic effect which stimulates and precipitates a subsequent new phase of fragmentation. In a previous paper I assumed that those fragmentations and subsequent integrations in the analytic session were the consequences of interpretations that 'click'. Now I am inclined to assume that these changes may also develop spontaneously in the analytic situation. The trauma of the interpretation adds to the effectiveness of the ego's fragmentizing function. I assume that the proper timing of interpretations coincides with the mentioned switches in fragmentation-integration. If this assumption proves correct, it may help to more objective determination of the proper timing of interpretations, since the fragmentation-integration phases may be discernible.

This would lend support to a more objective consideration of proper timing and would enable us to narrow down the role of empathy which still plays a considerable part in our daily clinical work.

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DEPENDENCE IN INFANT CARE, IN CHILD CARE, AND IN THE PSYCHO-ANALYTIC SETTING¹

By

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There is nothing new in the idea of dependence, either in the early life of the individual or in the transference which develops force as a psycho-analytic treatment gets under way. What I feel may need restating from time to time is the relationship between these two examples of dependence.

I need not quote from Freud. Dependence of the patient on the analyst has always been known and fully acknowledged, and for instance shows in the reluctance of an analyst to take on a new patient within a month or two of a long summer holiday. The analyst rightly fears that the patient's reaction to the break will involve deep changes that are not yet available for analysis. I will start with a development of this theme.

A young woman patient had to wait for a few months before I could start, and then I could see her only once a week; then I gave her daily sessions just when I was due to go abroad for a month. The reaction to the analysis was positive and developments were rapid, and I found this independent young woman becoming, in her dreams, extremely dependent. In one dream she had a tortoise, but its shell was soft so that the animal was unprotected and would therefore certainly suffer. So in the dream she killed the tortoise to save it the intolerable pain that was coming to it. This was herself and indicated a suicide tendency, and it was to cure this tendency that she had come for treatment.

The trouble was that she had not yet had time in her analysis to deal with reactions to my going away, and so she had this suicidal dream, and clinically she became physically ill, though in an obscure way. Before I went I just had time, but only just, to enable her to feel a connexion between the physical reaction and my going away. My going away re-

enacted a traumatic episode or series of episodes of her own babyhood. It was in one language as if I were holding her and then became preoccupied with some other matter so that she felt *annihilated*. This was her word for it. By killing herself she would gain control over being annihilated while dependent and vulnerable. In her healthy self and body, with all her strong urge to live, she has carried all her life the memory of having at some time had a total urge to die; and now the physical illness came as a localization in a bodily organ of this total urge to die. She felt helpless about this until I was able to interpret to her what was happening, whereupon she felt relief, and became able to let me go. Incidentally her physical illness became less of a threat and started to heal, partly of course because it was receiving appropriate treatment.

If illustration were needed this might show the danger of underestimating transference dependence. The amazing thing is that an interpretation can bring about a change, and one can only assume that understanding in a deep way and interpreting at the right moment is a form of reliable adaptation. In this case, for instance, the patient became able to cope with my absence because she felt (at one level) that she was now not being annihilated, but in a positive way was being kept in existence by having a reality as the object of my concern. A little later on, in more complete dependence, the verbal interpretation will not be enough, or may be dispensed with.

You will have observed that I could go in either of two directions, starting from such a fragment from an analysis. One direction would take us to the analysis of reaction to loss and so to the main part of that which we learn in our psycho-analytic training. The other direction

¹ A paper read to the Boston Psychoanalytic Society, October, 1962.

takes us to that which I wish to discuss in this paper. This other direction takes me to the understanding we have in us that makes us know that we must avoid going away just after starting an analysis. It is an awareness of the vulnerability of the patient's ego, the opposite of ego-strength. In innumerable ways we meet our patient's needs because we know what the patient is feeling like, more or less, and we can find the equivalent of the patient in ourselves. What we have in ourselves we can project, and find in the patient. All this is done silently, and the patient usually remains unaware of what we do well, but becomes aware of the part we play when things go wrong. It is when we fail in these respects that the patient reacts to the unpredictable and suffers a break in the continuity of his going-on-being. I wish to take up this point in particular later on in this paper, in discussing Zetzel's Geneva Congress paper (1956).

My general objective is to relate dependence in the psycho-analytic transference to dependence at various stages of infant and child development and care. You will see that I am involved in an attempt to evaluate the external factor. May I be allowed to do this without being thought to be going back on what psycho-analysis has stood for over the past forty years in child psychiatry. Psycho-analysis has stood for the personal factor, the mechanisms involved in individual emotional growth, the internal strains and stresses that lead to the individual's defence organization, and the view of psycho-neurotic illness as evidence of intrapsychic tension that is based on id drives that threaten the individual ego. But here we return to ego vulnerability and therefore to dependence.

It is easy to see why it is that psycho-analysts have been reluctant to write about the environmental factor, since it has often been true that those who wished to ignore or deny the significance of the intrapsychic tensions chiefly stressed the bad external factor as a cause of illness in child psychiatry. However, psycho-analysis is now well established, and we can afford to examine the external factor both bad and good.

If we accept the idea of dependence, then we have already started to examine the external factor, and indeed when we say an analyst should be trained we are saying that an essential for orthodox psycho-analysis is an external factor,

that is to say the *good enough analyst*. All this is self-evident, yet I can still find those who *either* never mention this external factor as if it were really important, *or else* talk about it all the time, ignoring the internal factors in the process. As Zetzel said in a seminar recently: first Freud thought all neurotic persons had had sexual traumata in childhood, and then he found that they had had wishes. And then for several decades it was assumed in analytic writings that there was not such a thing as a real sexual trauma. Now we have to allow for this too.

In a deliberate examination of the external factor, I am thus far engaged in relating the analyst's personality, capacity for identifying with the patient, technical equipment, and so on, with the multifarious details of child care, and then in a more specific way with the special state that a mother is in (father maybe too, but he has less opportunity to show it) in the short time space covering the later stages of pregnancy and the first months of the infant's life.

Psycho-analysis as we learn it is not at all like child care. In fact, parents who interpret the unconscious to their children are in for a bad time. But in the part of our work as analysts that I am referring to there is nothing we do that is unrelated to child-care or to infant-care. In this part of our work we can in fact learn what to do from being parents, from having been children, from watching mothers with very young babies or babies unborn, from correlating parental failures with subsequent clinical states of ill children. While we know that psycho-neurotic illness is not caused by parents, we also know that the mental health of the child cannot become established without good enough parental or maternal care. We also know that a corrective environmental experience does not directly cure the patient any more than a bad environment directly causes the illness structure. I refer to this again at the end of this paper.

I now wish to refer back to my fragment of clinical material. Very early in the analysis this patient had become represented in her dream material by frail and often maimed creatures, and now she had dreamed of the tortoise with a soft shell.² You will have noted that this points the way to a regression to dependence that is bound to come. The patient had had several years of analysis along ordinary lines by an analyst who disallowed

² By the way, she could also be a horse that had to be shot, else it would have kicked its way out of an aeroplane.

regression if this threatened to become acted out and to involve dependence on the analyst. She was therefore over-ripe for this part of the total analytic procedure, though of course needing as much as anyone else does the usual interpretations that become appropriate from day to day, or from minute to minute.

If I go a little further into the interpretative problem in the analysis of this fragment, I think I can show how interwoven are these two things: the intrapsychic mechanisms and dependence, which by definition involves the environment and its behaviour.

I had plenty of material in this case for the interpretation of the patient's reaction to my going away in terms of oral sadism belonging to love reinforced by anger—anger with me and all the others in her life who have gone away, including the mother who weaned her. I could have weighed in, fully justified in terms of what the patient had told me, but then I should have been a bad analyst making good interpretations. I should have been a bad analyst because of the way the material had been given me. All the time in our analytic work we are assessing and reassessing the ego strength of the patient. The material had been given me in a way that indicated that the patient knew she could trust me not to use it brusquely. She is hypersensitive to all drugs and to all illnesses and to slight criticisms, and I must expect her to be sensitive to any mistake I make in my estimation of the strength of her ego. Something central in her personality only too easily feels the threat of annihilation; clinically of course she becomes tough and extremely independent, well-defended, and along with this goes a sense of futility and of being unreal.

In fact her ego is not able to accommodate any strong emotion. Hate, excitement, fear—each equally separates off, like a foreign body, and all too easily becomes localized in a bodily organ which goes into spasm and tends to destroy itself by a perversion of its physiological functioning.

The reason why the regressive and dependence dreams have appeared has to do chiefly with her finding that I do not use every bit of material for interpretation, but that I store everything up for use at the right moment and content myself for the present with making preparation for meeting

the dependence that is coming up. This dependence phase will be very painful for the patient, and she knows it, and a risk of suicide goes with it, but, as she says, there is no other way. There is another way, for if her analyst is not able to meet her dependence so that the regression becomes a therapeutic experience, she will break down into psychosomatic illness, which produces the much-needed nursing but not the insight or the mental care that can really make a difference. The analyst needs to know why the patient would rather kill himself or herself than live under threat of annihilation.

By looking at this bit of material in this way, we reach a point where we are discussing both analysis and the meeting of dependence needs. A string of 'good' interpretations relative to the general content of the session would produce anger or excitement, and it is not yet possible for this patient to deal with these all-out emotional experiences. It would therefore be bad in the sense of my present statement of analytic procedure to interpret the very things that are relative to the premature separation.

In the course of a talk in which we made plans for the future and discussed the nature of her illness and the risks that are inherent in going on with the treatment, I said:³ 'So here is yourself ill, and we can see that the physical illness hides an extreme reaction to my going away, although you are not able to reach to a direct feeling-awareness of this. So that you could say that I have caused your illness, just as others have caused you to be ill when you were a baby, and you could be angry.' She said: 'But I'm not.' (Actually she holds me in an idealized position at present, and tends to find doctors of the body to be persecutors.) So I said: 'The path is there, wide open for your hatred and anger, but anger refuses to walk down the path.'

The patient told me that the main thing that brought about the very swift, involuntary development towards dependence was the fact that I let things be, and wanted to see what each hour would bring. Actually the pattern had been that she would start almost as if the hour were a social visit. She would lie down and display very clear intellectual awareness of herself and of her surroundings. I played in with all this, and there was much silence. Near the end of each hour she would quite unexpect-

³ I was clearly affected by the intellectual level of her method of presenting material.

tedly remember a dream, and she would then get my interpretation. The dreams presented in this way were not very obscure, and the dream resistance could usually be seen to reside in the 45 minutes of material that preceded it and that was not good material for interpretation. That which has been dreamed and remembered and presented is within the capacity of the ego-strength and structure.

So this patient will be very dependent on me over a phase; the hope is that for her sake, as well as for mine, this dependence will be kept within the confines of the transference and of the analytic setting and sessions. But how can one tell in advance? How can one make this sort of diagnosis that is concerned with assessment of needs?

In terms of *child-care*, I would like to exemplify regression in the service of the ego by looking at the phases of spoiling which parents find one child needs from time to time—parents, that is, who do not spoil their child because of their own anxieties. Such phases of spoiling bring many a child through without any involvement of a doctor or a child guidance clinic. It is difficult to give a case without making it sound rare, and these are matters of common experience in family life, when parents care for their own children. For a few hours, or days, or weeks, in a special context, a child is treated as if of a younger age than is in fact true chronologically. Sometimes it happens when a child bangs his head or cuts his finger; he goes in a moment from 4 to 2, and is screaming and consoling himself with his head in his mother's lap. Then in no time, or after a sleep, he is again very grown up, and more so than his own age warrants.

Here is a boy of 2 (Winnicott, 1963). He reacted very badly at 20 months to the mother's anxiety which she experienced when she conceived. It is part of her pattern to become extremely anxious at conception. He stopped using the pot and stopped using words, and his forward progress was held up. When the baby was born he was not hostile to the baby, but he wanted to be bathed like the baby. At breast-feeding time he started thumb-sucking, which had not previously been a feature. He made special claims on the

parents' indulgence, needing to sleep in their bed for many months. His speaking was delayed.

The parents met all these changes and demands in a satisfactory way, but the neighbours said that they were spoiling the boy. Eventually the boy emerged from his regression or withdrawal and the parents were able to finish with spoiling him when he was 8 years old, after he had had a phase in which he was stealing money from them.⁴

This is a common type of case in child psychiatry as I know it, especially in private practice when children are brought for symptoms that in child guidance might be considered to be insignificant. It has been an important part of my child psychiatry orientation to recognize that in such a case one does not immediately think of psycho-analysis; one thinks of supporting these parents in their management of their child's babyishness. One may be in a position, of course, to give psycho-analytic help, while the parents are carrying out the mental nursing of the patient, but it is a formidable matter to treat such a case by psycho-analysis if there is not a parental provision that will meet the mental nursing needs. Without the parents' mental nursing the psycho-analyst doing psycho-analysis must find the patient not only dreaming of being taken over by the analyst and into his or her home, but also actually needing to be taken in.

A corollary of this that when an orthodox psycho-analysis of a child is successful there is an acknowledgement to be made by the psycho-analyst that the parents' home, relations, helpers, friends, etc., did nearly half the treatment. We do not have to make these acknowledgements out loud, but we need to be honest about these matters of the patient's dependence when we are theory-building.

Now I come to the earlier *infant-mother relationship*. A great deal has been written about this. I want to draw your attention to the part the mother plays at the time of her baby's very great dependence at the beginning. Although I believe readers are fully aware of these matters, I wish to go over the argument again so that it can be discussed.

Here I wish to refer to a paper by Zetzel (1956). I need not gather together all the threads that

⁴ Miss Freud has recently (1963) taken up the subject of ego-regression in a paper published in the *Menninger Bulletin*.

went to the making of this very valuable review of Current Concepts of Transference. I only want to take out of her paper the paragraphs in which she refers to my own work. She writes: 'Other analysts—Dr Winnicott, for example—attribute psychosis mainly to severe traumatic experiences, particularly of deprivation in early infancy. According to this point of view, profound regression offers an opportunity to fulfil, in the transference situation, primitive needs which had not been met at the appropriate level of development. Similar suggestions have been proposed by Margolin and others . . .'

It is valuable to me to have the opportunity to take up this description of my attitude to this subject, a subject that has great importance because of the fact that one of the growing points of psycho-analysis is in the treatment of the borderline case and in the attempt to formulate a theory of psychotic illness, especially schizophrenia.

Firstly, do I attribute psychosis mainly to severe traumatic experiences, partly of deprivation in early infancy? I can well understand that this is the impression that I have given, and I have changed the way I present my view in the course of the past decade. It is necessary, however, to make some corrections. I have definitely stated that in the aetiology of psychotic illness and particularly of schizophrenia (except in so far as hereditary elements are operative) there has to be noted a failure in the total infant-care process. In one paper I went so far as to state: 'Psychosis is an environmental deficiency disease'. Zetzel uses the term 'severe traumatic experiences', and these words imply bad things happening, things that look bad from the observer's point of view. The deficiencies that I am referring to are failures of basic provision—like my going away to the U.S.A. when my patient is not ready for the reactions that occur in her to my going. In other papers I have explored in great detail the kinds of failure that constitute failure of basic provision. The main point is that these failures are unpredictable; they cannot be accounted for by the infant in terms of projection, because the infant has not yet reached the stage of ego structuring that makes this possible, and they result in the *annihilation* of the individual whose going-on-being is interrupted.

Mothers who are not themselves ill do in fact avoid this type of failure of care of an infant.

Under the heading 'Primary Maternal Pre-occupation' I have referred to the immense changes that occur in women who are having a

baby, and it is my opinion that this phenomenon, whatever name it deserves, is essential for the well-being of the infant. It is essential because without it there is no one who is sufficiently identified with the infant to know what the infant needs, so that the basic ration of adaptation is missing. It will be understood that I am not just referring to adaptation in terms of the satisfying of id-drives.

A basic ration of environmental provision facilitates the very important *maturational developments* of the earliest weeks and months, and any failure of early adaptation is a traumatic factor interfering with the integrative processes that lead to the establishment in the individual of a self that goes on being, that achieves a psychosomatic existence, and that develops a capacity for relating to objects.

So a statement of my view would include the following:

- (i) It is in psychoneurotic illness that we find the conflicts that are truly personal to the individual, and relatively free from environmental determinants. One needs to be healthy enough at the toddler age to achieve psychoneurotic illness, let alone health in this area.
- (ii) It is in the earlier stages that the basis of the mental health of the individual is being laid down. This involves:
 - (a) maturation processes, which are inherited tendencies, and
 - (b) the environmental conditions that are needed if the maturational processes are to become actual.

In this way, failure of early basic environmental provision disturbs maturation processes, or prevents their contributing to the individual child's emotional growth, and it is this failure of the maturation processes, integration, etc., that constitutes the ill-health that we call psychotic. This failure of the environmental provision (privation) is not usually referred to by the word 'deprivation', hence my need to correct the words of Zetzel's reference to my work.

- (iii) A complication in the making of this statement is the fact that there is an intermediate position, one in which environmental provision is at first good, and then fails. It succeeds in that it allows of ego organization of considerable degree, and then it fails at a stage before the individual

has become able to establish an internal environment—that is, to become independent. This is what is usually called a ‘deprivation’, and it does not lead to psychosis; it leads to a development in the individual of an ‘antisocial tendency’, which may in turn force the child into having a character disorder and becoming a delinquent and a recidivist.

All these over-simplifications need elaboration which I have given them elsewhere but which I cannot gather together here. I wish, however, to refer briefly to a few of the effects of this attitude to mental disorder on our way of thinking.

- (i) One is that it is in the psychoses—not in the psycho-neuroses—that we must expect to find examples of self-cure. Some environmental happening, perhaps a friendship, may provide a correction of a failure of basic provision, and may unhitch the catch that prevented maturation in some respect or other. In any case, it is sometimes the very ill child in child psychiatry who can be enabled to start growing by snack-bar psychotherapy, whereas in the treatment of psycho-neurosis one always wants to be able to provide a psycho-analytic treatment.
- (ii) The second is that a corrective experience is not enough. Certainly no analyst *sets out to provide* a corrective experience in the transference, because this is a contradiction in terms; the transference in all its details comes through the patient’s unconscious psycho-analytic process, and depends for its development on the interpreting that is always relative to material presented to the analyst.

Of course, the practising of a good psycho-

analytic technique *may* in itself be a corrective experience, and for instance in analysis a patient may for the first time get full attention from another person, limited though it be to the reliably established 50-minute session; or may for the first time be in contact with someone who is capable of being objective. And so on.

But even so, the corrective provision is never enough. What is it that may be enough for some of our patients to get well? In the end the patient uses the analyst’s failures, often quite small ones, perhaps manoeuvred by the patient, or the patient produces delusional transference elements (Little, 1958) and we have to put up with being in a limited context misunderstood. The operative factor is that the patient now hates the analyst for the failure that originally came as an environmental factor, outside the infant’s area of omnipotent control, but that is *now* staged in the transference.

So in the end we succeed by failing—failing the patient’s way. This is a long distance from the simple theory of cure by corrective experience. In this way, regression can be in the service of the ego if it is met by the analyst, and turned into a new dependence in which the patient brings the bad external factor into the area of his or her omnipotent control, and the area managed by projection and introjection mechanisms.

Finally, in regard to the patient to whom I have referred, I must not fail in the child-care and infant-care aspects of the treatment until at a later stage when *she will make me fail* in ways determined by her past history. What I fear is that by giving myself the experience of a month abroad I may have already failed prematurely and have joined up with the unpredictable variables of her infancy and childhood, so I may have truly made her ill now, as indeed the unpredictable external factors did make her ill in her infancy.

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A CASE OF TRANSVESTISM WITH MULTIPLE BODY-PHALLUS IDENTIFICATION¹

By

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In the following case report of a male transvestite a series of body-phallus identifications was used by the ego not only as a regressive flight from castration threat but also as a means of stabilizing an impaired body image and preserving precarious object-relations.

The patient, aged 21, was in analysis while attending graduate school in this city for four years. His complaint was 'an urge to put on female clothing', with the thought 'I am not a man; I am a girl'. Typically, he would fantasize that while at a delightful resort with his older sister circumstances arose which made it perfectly natural for him to dress in her clothes; they were then sweet, lovable young girls together in silk and nylon. Mother too sometimes appeared in the fantasy and accepted it as natural for him to be wearing female clothes, but never father. Double-dating or dancing with boys might be included in order to emphasize that he and his sister were girls together, but there was never anything sexual with these boys; in fact he found the thought of homosexuality repulsive. To heighten the fantasy, the patient would put on some of his sister's clothes before a mirror, then add a tight belt around the waist and push his penis between his thighs so that his body contours even more resembled a girl's. This description of his transvestite behaviour contrasted strikingly with his actual very masculine appearance.

These urges were especially frequent when he was under stress, for example an examination or athletic competition, at which times he felt keen envy of women's protected position. The fantasy would end with masturbation and ejaculation, following which he would feel ashamed and humiliated and despair of ever

being able to get married while doing such a bizarre thing. Hence he struggled against the transvestite urges by trying to think sexually of girls; but these girls to be really exciting had to be so absolutely beautiful that he was sure that only the models or movie stars of New York or Hollywood could fulfil the requirements. He spent much time and energy searching for the 'beautiful girl'. Whenever he actually found a girl whom he considered pretty, he flaunted her before his friends, but each time as he came to know the girl better he would find some grounds for rejecting her.

His childhood he pictured angrily as a world of women: mother, sister, maternal grandmother, an unmarried maternal aunt, and the maid. Until the age of 7 he slept in the same room as his 5-years-older sister, who tyrannized over him while he followed her around like a puppy. She had always been a tomboy; now she had a doctorate in her professional field, and though married three years, was still childless, so she must be 'masculine'. Mother, who had her professional office at home, was unquestionably the boss of the household, and she too was 'masculine'. Father was a peripheral figure, either shouting ineffectually or else away at work; the women, on the other hand, had a warm intimacy which he yearned to share but from which, being a boy, he was excluded. Hence he treasured a strikingly vivid memory from the age of 3 or 4 of standing in the bathroom while his mother and sister, who had dressed him in one of sister's slips, looked at him fondly, while he was happy and excited and his penis tingled.

Until about age 10 he continued timid,

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enuretic, a 'sissy' dominated by his sister. But around puberty his outward personality began to change; he grew tall and strong and became the seeming epitome of the 'normal male'. At college he was athletic, had many dates, and even a steady girl friend. He now felt that his mother admired this maleness and that her eyes shone as she watched him walking with a beautiful girl, while he felt sexually excited. But at the same time that this 'normal' maleness, or even hyper-masculinity, appeared, so did the transvestite masturbation fantasy, for his first ejaculation at age 12 or 13 was while dressed in one of sister's slips. Petting with his girl friend was sexually arousing and he would even have orgasm; the next day, however, he would regress to a transvestite fantasy of quiet contentment as a little girl with his sister.

As patient's fantasies of closeness with mother and sister and transvestite fusion of identities with them came under analysis, it became evident that not only did he endow them with a penis, but also that he assigned to the whole person of mother and sister a phallic quality (Fenichel, 1930, 1936). He constantly spoke of their capacity to be 'forceful', to 'thrust' suddenly at him with some unexpected demand, to be 'penetratingly' intellectual. When he flaunted the tall, erect, devastatingly 'beautiful girl' in front of his friends, he felt he was demolishing them with her and thus making up for the felt inadequacy of his own 'little penis', and it was when the girl became to him more a person and less an appendage that she lost her attractiveness for him.

During the first year of analysis, the patient's efforts to free himself from these identifications with mother and sister took various forms. He recalled bitterly how when he was a little boy mother ignored their sex difference by bathing with him, and then had fought his efforts to declare himself a male by insisting on bathing him until he was 12; moreover she had made him wear 'sissy' clothes instead of blue jeans like other boys and unduly limited his riding his bicycle. He therefore tried harder than ever to differentiate his body image from her concept of him by changing from his usual hair-cut style and clothes to a crew-cut and black leather jacket and bought a motor-cycle, all of which she detested. He dreamed that a hungry, devouring alligator almost tipped over a boat, and tried to end

his continued incorporating of her body by refusing to eat the food packages that she sent him, claiming that these now nauseated him. He stopped writing, telephoning, or visiting mother as he had always regularly and compliantly done, and refused too to have anything at all to do with his sister. Pressed by his girl friend about marriage, he dreamed of a shark biting her and broke off with her on the stated ground that now she wore glasses, she was not so 'beautiful' any more, and since she was so outstanding scholastically, she too was 'masculine' like mother and sister.

During this period in the analysis after he had broken away from all ties with women, he would posture before the mirror admiring himself dressed as a girl with big, perfect breasts. The transvestite fantasy, which earlier had emphasized the closeness with mother and sister, now took on the meaning of 'I am my own beautiful girl'. But this attempted narcissistic solution, of taking his own body clothed as a girl as the object, was not an entirely satisfactory one, for in his loneliness he now thought longingly of mother as a 'benevolent despot who had supported him in luxury', and recalled the happy times when his sister and her girl friends had included him in their play. Moreover, transference phenomena now began to appear in relation to me as a male, for though he still tried in his descriptions of the masturbation fantasy to emphasize the soft women's clothes and the protected closeness with mother and sister, he found it progressively harder to deny that he enjoyed his penis, its erection and ejaculation. He remarked with pleasure that he was taller than I or that his car was newer or more expensive than mine. But then he immediately felt that his penis was excessively small, and I seemed to him grim and austere and this city bleak and barren. Only during the transvestite fantasy did he feel relief from painful concern over this smallness of his penis, as though the picture in the mirror of his whole body dressed as a 'beautiful girl' was at the same time a picture of a reassuringly large penis. Here we see the identification of his phallus not only with the body of mother and sister but also with his own body.

When the patient first came to analysis, relatively secure in his hypermasculine self-image, he was detached about other men and felt that he 'had no trouble with them'. But

now, with increasing awareness of his phallic drives, it became clear that he was in fact constantly anxious about being surpassed not only by me but also by all other men, whether fellow students, instructors, or his father. He therefore strove unremittingly to be 'Number One', but since most of the time he felt hopelessly outclassed by other males, he would abdicate in advance from competition with them; for example, in class he was sometimes almost overcome by the impulse to shout out to the instructor, 'I'm only a girl; don't ask me questions'. He now recalled that at age 4 to 7 when he had nightmares of walking among biting snakes, which made him run to mother's bed and sleep with her the rest of the night, father finally ordered him to stop this. Hence by the transvestite fantasy he was trying to say to father, as he almost did in the classroom, 'I'm only a girl; don't punish (castrate) me'. When he used to undress in his sister's presence, as they slept in the same room, he would feel tremendously excited but also frustrated; he would even get into her bed, but all the time pretending sexual unawareness and detachment just as mother did towards him when she bathed him.

The realization that this detached 'no trouble with them' self-image was only a façade, generated in him tremendous rage, manifested especially in the transference. He protested that it was 'sissy' to lie on the couch and complained bitterly because I held him so 'rigidly' to the appointment schedule, thus preventing him from having a long weekend to look for a 'beautiful girl'. Because of my 'unyielding attitude' his thoughts could no longer dwell on delightful transvestite fantasies of being with his sister; instead, they had to turn realistically to whether to miss school and analysis by going on this trip. Next hour, he came late because he had been fascinated by a magazine article about boys with abnormally large breasts; girls with boyish haircuts also interest him. As he dwelt on this and I interpreted it as flight from last day's struggle with me into a comfortable blurring of sexual differences, his irritation became so intense that he left the session early.

Next hour, he said he had felt imprisoned last time, held down by my magic wand, cut off from the beautiful girls of New York and Hollywood by the analysis here, while all the time he is getting bald and therefore less

attractive. Suddenly he recalled a fear that a large Negro, who had stared at him as he urinated in a movie theatre washroom, might cut off his penis with a knife; then had come the thought that he would accept this, otherwise the man might cut his heart out and kill him, which would be worse. He realized that I keep him to his appointments for his own good, but then he wondered, was I greedy for the fee? From all this horror he deliberately turned his thoughts to his sister's kind pretty face, just as he had used to during horror movies as a child. Again he compared my car unfavourably with his own, then wondered if he was getting much in the analysis; he has to give me a cheque in order to receive, whereas a girl has it easier; she merely opens her vagina and there is always a man ready to feed her. He then pleaded persuasively that I call him by his first name and thought of trying to become acquainted with me socially, to reduce the terrifying distance between us.

The foregoing material illustrates that for him to give up his hypermasculine image of maleness and accept the help-seeking position of the analysand signified terrifying castration. But, in addition, he behaved as though I would unquestionably view him with the same fond admiration as mother had done when he walked beside his girl friend: his astonished rage when I questioned his hypermasculine defence and refused to switch appointments to suit his convenience sounded as though he had felt we were part of one another, with our needs fused and his gratification also mine; perhaps he even acted as my penis for me, for on the few occasions when it occurred to him to wonder about my sexual life, he doubted whether I had any. This same underlying need of his impaired ego for object-relationship also forced him to experiment with accepting castration and a passive homosexual position towards me, as in his suggestion that it might be better to let the Negro (analyst) cut off his penis than to suffer total annihilation and therefore total object-loss, for as a castrated being with a vagina he would be assured of a constant flow of supplies.

At this point in the analysis, now in its third year, the patient still vehemently repudiated such homosexual notions. In succeeding hours, however, he went on to acknowledge some genuine dependence upon me. For instance, he mournfully told me that because

I had cancelled an appointment he had had many transvestite fantasies; he had therefore thought, 'To hell with it, what's the use of going through the agony of talking, analysing, trying to date girls, if Dr Lewis doesn't care about me and just cancels out; I might as well go to Denmark and have the operation and become a girl with a vagina; I can't get a girl so I might as well make myself into a girl'. Thereupon he had drawn the belt tightly about his waist, pushed his penis back between his thighs until it hurt, and fantasied finding a man who would put his penis into patient's newly-made vagina; he even thought of me as the man, but switched to a former roommate as more rugged-looking. Angrily he went on that he knew if he were a girl I would view him more sympathetically and wouldn't cancel appointments; it is because I won't help him to get a really beautiful girl that he is reduced to this putting a belt around himself and thinking himself a girl.

In this sequence, then, he expressed the idea that as long as I, as a father, withheld from him my penis (the 'beautiful girl'), he was incomplete, a castrated being. He now went on to the incestuous use he would like to make of father's penis if he only had it: . . . Though he is angry, it is nothing personal . . . I have my private life, and he's not interested in it; . . . no, he doesn't speculate about why I cancelled the appointment; why do I insist that he talk about this; it's as though father were saying, 'It's my wife, it's my bed, get out'; patient admits this so why should father keep saying this over and over. He has no intention of talking with father or asking him for help as he thinks I have been hinting; father is authoritarian and insensitive . . . like a truckdriver.

Next session, he reported a dream that he was in bed with a girl; she was naked, soft, and nice; no intercourse with her; maybe it was mother, because she was plump and older. If he comes to father with a problem, it's being a sissy, it shows softness . . . ; but on the other hand, perhaps father's authoritarianism is really a sham; maybe father is really burdened and harassed; if patient goes on to get really good professional training, he will have outdone father, whose own training was mediocre; . . . but then again father would have paid for every bit of that training.

Formerly therefore he had been able to maintain that father was passive and weak,

while he (patient) was remarkably masculine and virile. But now, under the impact of the analysis, a terrifyingly powerful, castrating image of father (the authoritarian truck-driver) emerged into awareness. He told bitterly how when he had shown athletic talent, father had immediately seized upon it and made him endlessly practise and play in tournaments, so that father could boast about him and show him off; yet no matter how hard he tried or how well he succeeded, father always wanted more. As he described father's loud voice, gruff manner, and strivings for financial success, it became evident that the patient's hypermasculine behaviour had derived in part from identification with his father as well as from his efforts to differentiate himself from the symbiotic fusion with mother.

The patient now went on to dream that he had intercourse with his sister, with anxiety lest he had made her pregnant. I interpreted this as re-enacting the time when father ordered him out of mother's bed and patient's logical next step would have been to try sister. As though to anticipate my thereupon ordering him out of his sister's bed, he promptly insisted how unattractive she is. But he was nevertheless able, for the first time, to talk with her about their childhood, and her rôle in the genesis of the transvestism became clearer. When he was small, she used to dress him like a doll in girl's clothes or in a ridiculous 'doggie' suit of shiny feminine material with a long tail; later she dressed him as a girl every Halloween. When they had a horse, she rode it but never allowed him to. When they slept in adjoining beds, there was much sex play; but when he got an erection, she would cut at him painfully with the side of her hand on the back of his neck and shout, 'You're a girl!' So this was when he began to put his penis between his thighs and tell *himself* that he was a girl. His sister used to dress as a male and put something in her pants to simulate a penis; to this day, when she hears about an accident to a man, she gets anxious that perhaps his genitals have been cut off.

This long-continued use by sister as a doll, as a long-tailed appendage to herself, undoubtedly intensified his body-phallus identification and his body-phallus model of object-relations. It became apparent that not only could a girl be his erect phallus, as we saw earlier, but also that he could be the girl's

phallus. When mother and sister looked at him fondly while he was dressed in sister's slip and his penis tingled, or when mother watched with eyes shining as he walked excitedly with the 'beautiful girl', he was a part of them, and they felt his feelings with him. But that he could be the girl's penis also filled him with fear; wary of being used or manipulated by the girl he withdrew from her as soon as she showed any assertiveness or competence; on the contrary, he tried to use her as an appendage to himself, a penis to wield against other men.

By now, near the end of his third year of analysis, the patient's transvestite, phallus-girl fantasy had become less tenable, and so had the hypermasculine defence against it. He had given up the black leather jacket and the recklessly-driven motor-cycle, and clung less insistently to his 'Number One' position and to his long-cherished idea that he had a special 'in' with mother in contrast to her supposed contempt for father. After a trip with his parents, in which they shared a hotel room while he slept alone in the next room, he had to admit that they probably did have a sexual life. His awareness of being the son, subordinate to and dependent upon his father, made him fear again that father would use him to show off patient's athletic prowess, as a well-performing masculine appendage. To ward off thus becoming father's phallus, he tried again to make me into a maternal, giving figure, longing for me to telephone him encouragingly every night before his examinations as mother had done. When he failed in this, he had to report just before summer vacation that, for the first time in his life, he had fantasied that he was a girl keeping house for father and father was having sexual relations with him. Earlier in the analysis, when hurt at my cancelling an appointment, he had toyed with a surgically-made vagina and a homosexual relation without feeling particularly anxious. But now, with his defences crumbling, this fantasy about father shocked and alarmed him, and he felt like punching me in the nose, for he blamed me for it. During the summer vacation, a sense of disorganization overtook him; he frantically tried to control this by sexual relations with one girl after another; and when this failed, he sank into days on end of feverish transvestite masturbation, becoming practically a recluse. But as the return from vacation to

analyst approached, this threatening panic spontaneously ended.

It appears, therefore, that as his father became an increasingly real person to him, and his subordinate needful position toward both father and analyst was brought home to him, pressure mounted for a passive homosexual solution to his relationship with these males. But homosexuality, which to him meant femininity and castration, perhaps brought such panic because with his unusually sensitive body-phallus identification, as soon as the integrity of his penis was threatened so was his whole sense of bodily intactness; he then became split and fragmented.

His fourth and final year of analysis included many further efforts to explore and get better acquainted with what a male is really like, even though this process reminded him of the old nightmares of walking among biting snakes. To this end, he had his father visit him, and he worked more realistically at his professional studies. His former tendency to pretend naïveté or detachment about his sexual needs lessened, and he made a more forthright and sustained effort at a relationship with a girl. There was no doubt, however, that these efforts at reality-involvement and new object-relations were also partly a defence against the impending separation from the analyst, to avoid suffering again the body-disintegration anxiety of the previous summer. When he left, though his transvestism had lost some of its old intensity, he intended to continue his analysis elsewhere.

Discussion

That this patient's transvestite behaviour served as a defence against castration anxiety is obvious, for by means of it he was enabled to maintain the use and enjoyment of his penis even though he had to do so secretly, in a masturbatory fantasy, and concealed under women's clothes. Viewed from this standpoint, the various fantasies of fusion with mother were undoubtedly in part regressive flights from castration threat. But it is likely that there was already, when the patient entered the phallic phase, a weakness in early ego development and an unstable body image formation which sharpened the castration problem. Greenacre's (1953) detailed discussion of this same question for fetishism has many relevancies here. The analysis of this man brought much evidence that for him castration, the loss or lack of a penis,

was only the prelude to total disintegration of his precariously-held body image, and that it was against this that he was violently defending. This body-disintegration anxiety was probably based first of all on mother's not allowing him to experience fully the boundaries and dimensions of his own body, but instead forcing him into excessive contact, especially close visual contact, with women's bodies, certainly in his bathing with her and his sleeping with sister. How much of this was contributed to by a constitutional predisposition in him for intense prolonged clinging must remain uncertain (Mahler and Gosliner, 1955). In either case, since the developing body image is based not only on the various sensory perceptions of one's own body but also on one's sensory perceptions of others' bodies, the result could well have been a state of primary identification with the powerful, active, preoedipal mother with, as Greenacre (1953) says, 'a well forecast bisexual splitting of the body image even antecedent to the phallic phase'. The oral-aggressive quality of his object-relations, in which he was the greedy shark or alligator on the verge of devouring or being devoured, tends to confirm this view of pregenital damage.

The onset of phallic sensations and awareness did not bring to an end mother's despotism over his insecure and bisexually-clouded body image, for she determinedly ignored the existence in him of the organ that would have clearly differentiated his body from hers, thus forcing him similarly to ignore and be detached from his phallic drives, while father appears to have been relatively devalued or absent as a model for a firmly masculine body image. He seems, therefore, never to have defined clearly from the rest of his body his genitals, their shape, their outline, or the sensations coming from them. Furthermore, whatever *was* differentiated from the rest of his body as genitals, by being seen and felt, was then fused by visual and tactile introjection with the intimately-seen and -felt genitals of the opposite sex.

The final choice of symptom appears to have been determined by his sister's dressing him as a doll and as a girl, her sex play with him, and her attacks upon his erections, which led to his *himself* pushing back his penis between his thighs and dressing *himself* as a girl. Even in this, his mother may have further undermined his body image and strengthened their symbiotic relationship, for his sister's behaviour towards him surely could not have continued over a period

of years without mother's at least unconscious sanction (Johnson, 1953). His response was to introject her coercive attitudes to his body, specifically his penis, so that on the one hand, dressed as a woman, he put it between his thighs and symbolically destroyed it, while on the other, he made his whole body tall, athletic, hypermasculine, 'Number One', as though to become *in toto* sister's (and mother's?) longed-for penis. Fenichel (1936) wrote that his transvestite patient identified himself with a woman whom he wished to believe possessed a penis; also that in the transvestite act he 'represented not only a phallic girl but also a phallus pure and simple.' From this, Fenichel went on to derive the symbolic equation girl=phallus, which we have seen in this patient's use of the 'beautiful girl' as a phallus. Fenichel then continued with a case description of a girl who pictured herself as her father's cherished penis, inseparably united with him, the most important part of his body without which he would be powerless, his magic wand, etc. Similarly in the patient here described, his body was not just a phallus 'pure and simple', but his sister's (and mother's?) phallus, a valued part of her, fondly played-with and admired. By thus sacrificing his total body identity he achieved a safe part-identity. This identification of the transvestite with the female phallus has been described by Greenacre (1955) in her book on Jonathan Swift.

But that he could be thus used as a woman's phallus threatened again his unstable sense of self; hence in his private transvestite fantasies he warded off his body fusion with women by taking his own image in the mirror as his 'beautiful girl', while by his outward hypermasculinity he behaved as though his entire body were a phallus and thus totally differentiated from anything feminine. Moreover, instead of being the woman's phallus, he tried on the contrary to use women as an appendage to himself, a penis to wield against other men.

The onset of phallic drives, however, also brought him inexorably into a world of males which to him meant 'walking among biting snakes'. In order then not to be castrated at the hands of a remote, insensitive, 'authoritarian truckdriver', he attempted to use with males some of the same modes of object-relation that he had experienced with women. He tried in relation to men to make his whole body a victorious phallus; alternatively he behaved towards men as though he had no phallus at all, by falling back into transvestite oneness with

women. He regressed in his homosexual fantasies into being a receptive mouth-vagina for males as he had been with mother, and he tried out being father's proudly-exhibited phallus as he had been sister's.

Erikson (1959) has said: '... children become aware of the attributes of maleness, and learn to love men's physical touch and guiding voice, at about the time when they have the first courage for autonomous existence... autonomous from the maternal matrix...'. In this patient's childhood world of women, neither autonomy from the maternal matrix nor awareness of the attributes of maleness had come about sufficiently. Part of the function of the analysis, therefore, in addition to helping him delineate his body image from the various fusions with mother's, was to make it possible for him to acquaint himself, first in the transference and then in the real world, with the previously remote, unreal father, and therefore to make less necessary all his various defences against relationships with males. For this reason, when he measured his body and his car against mine or tried to get on a first-name basis with me, I recognized with him that these represented a boy's efforts to get to know what a male is like; but at the same time my clearly maintaining my rôle as analyst against his attempted seductions and threats equally helped him to gain a picture of a male as having the capacity to maintain his identity.

Summary

An outwardly masculine man with a transvestite masturbation fantasy appeared to have suffered an early disturbance of body image formation. Then upon entering the phallic phase, the genital area of the body image, instead of differentiating out clearly from the

rest of the body, remained fused with it, thus laying the basis for pervasive body-phallus identifications and for castration anxiety to become merged almost immediately with total body-disintegration anxiety.

The specific transvestite symptom derived from his older sister's long-continued use of him for sex play, in which she dressed him as a girl and as a long-tailed dog and beat down his erection painfully, leading him to push back his penis between his thighs and dress himself as a girl. By doing this, he became an appendage to his sister, her yearned-for penis, united to her (and through her to mother?) in intimate symbiotic object-relation. But that he could be used as a woman's phallus threatened again his insecure sense of self, so in his private transvestite fantasies he warded off this body fusion with women by becoming his own phallic 'beautiful girl', while in his daily life he tried to differentiate himself from women by excessive masculinity, behaving as though he were *in toto* a tall, erect phallus. Moreover, instead of being the woman's phallus, he tried to use attractive women as a phallus with which to demolish other men.

These various modes of object-relation that he had experienced with women were now used with males. Hypermasculinity and being 'Number One' among men, which originally arose in order to differentiate his body image from fusion with mother's, was now used to deny any needs for closeness with males; or alternatively, he could become through it, by his athletic triumphs, father's proudly-exhibited phallus. Transvestism, originally arising in a situation of need to do away with his penis so that he could become *in toto* the woman's phallus in symbiotic fusion with her, now served as a concealment under which he could preserve some degree of phallic function.

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ON FETISHISM

By

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The past few years have seen a revival of interest on the part of psycho-analysts in the many problems of fetishism, not only because of the central position it occupies within the important group of the sexual perversions, but also because of its unique capacity for shedding light upon the early history of the ego and of the instincts, to both of which problems this paper is a contribution. There is little need to review the work which allows current studies of fetishism to stand upon such sure ground while advancing further inquiries; this has been done admirably by both Greenacre (1953) and Gillespie (1956), the latter in a particularly comprehensive and synthetic manner, and both have contributed notably to our more recent understanding.

The clinical material here set forth is from the analysis of a man who presented himself with the hope of being rid of the sexual attraction which mackintoshes held for him, an attraction with which was associated the deepest guilt. Superficially his sexual relationships with his wife seemed satisfactory, but his sexual power required periodic reinforcement through bouts of fantasy in which adolescent girls appeared tightly wrapped in mackintoshes. The sight of such girls on the street clad in rain capes was intensely exciting, as were pictures of mackintoshes in advertisements or the sight of them in clothing stores. The guilt and depression which followed such excitement was often intense, and indeed this misery was the principal conscious factor in preventing him from ever having sought a sexual partner with whom to consummate his fantasies in fact.

Typically, his fantasy portrayed an innocent girl, wearing the fetish cloak, in an attitude of servitude and humility as though under the ordinance of a strict governess and in the willing acceptance of a stern upbringing. At times this portrayal was elaborated by the cruel

tightening of the sash of the mackintosh about the girl and, for the sake of greater excitement, by her submission to a whipping; all this, too, being accepted as a just and expected part of the young girl's tutelage. These fantasies had been preceded during his own adolescent years by others in which he himself had worn the exciting garment and had received similar stern treatment at the hands of his elders. Indeed, one of his first ejaculations, just after his fifteenth birthday, was accompanied by the fantasy of his school teacher, a man, tying him up in a mackintosh and pulling him down the street on a chain. But even before this, which was the first moment of conscious association of his sexual feelings with the idea of a mackintosh, he had long attached special meaning to this article of clothing. One of his earliest memories of this kind came from his seventh or eighth year; it was a rainy day and his father was helping him on with a mackintosh. Feelings of humiliation, of being trapped and helpless, remained vividly connected with this scene. These feelings were characteristic of those he held towards his father, a strict, stern, brusque man who often seemed harsh and cruelly cold. 'I always thought of him as a ball of fire which might erupt or explode into a tremendous fury if you ever crossed him. I always felt that his fury was right and just which gave me a tremendous feeling of guilt.' The righteousness and justice which he felt in his father's anger came to find its place in his later fantasies. The righteousness of the punishment provided it with its real horror: stories and pictures of the Spanish Inquisition were fascinating and horrifying, not so much because of the nature of the atrocities performed, but because they were carried out in the name of right.

From his father, a man who had been moulded by his military career, he learned the penalties of cowardice. This was held to be the greatest

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of sins, and stories of how the troops would urinate on the dead bodies of their cowardly fellow soldiers filled him with shame as well as horror, for he felt that inwardly he himself was the despicable coward who at a time of crisis would 'let the regiment down'. But in spite of the premium his father placed upon 'being a man', it was clearly dangerous to be one in his presence. During his early school years it had been his sport on his way to school to jeer and call names at the workmen in the road. Later, an occasion arose to make some retort to his father, who had instantly seized him, turned him upside down, and thrashed him. This was the last time he was to show any signs of aggressiveness towards his father. Thereafter he was afraid of encountering any workmen in the road, and he had to be accompanied on his way to school.

When he was in his middle 20s his father died, and he immediately felt that now he was free to become a man and to govern his own life. But the bondage to his father soon made itself felt within the analysis, and foreshadowed a transference which was to assume all the characteristics of the state of sexual enthrallment (Parkin, 1962). During the first hour he was somewhat alarmed at not being able to begin by chatting at the desk, and he was filled with anxiety while first lying on the couch. The consultation room had a gloomy and foreboding appearance, and he felt himself once more to be in the presence of a man who would despise him as a weakling and condemn him for what he had to say. He pictured me as an army major who had summoned him under guard to hear the charge read and to be led away to his deserved punishment. At other times I was a cold and immaculately correct physician who, after brusquely examining him, would dispatch him to his fate. This situation was the setting during the early months of the analysis for a dream in which, while examining him about the perineum, I discovered some of his semen on my hand. As a boy he had often been made to stand in silent humiliation before his father who would manually examine his testicles. The reason for these seductive examinations was never clear, although he later assumed them to be signs of his father's preoccupation with the importance of being able to breed well, like pedigreed cattle, and with the danger of his becoming 'tainted stock' which would die out. The fear of his own 'taint' being discovered by his father found new expression in his apprehension lest some hidden

deficiency be revealed by the analysis, and was accompanied by an almost resigned acceptance of my anticipated disapproval and displeasure. At such times his analytic hours were filled with fantasies of being wrapped in a mackintosh and passively prostrating himself. He became aware of his feminine identification with the young girls of his daydreams, and he recalled the fantasy in which his school teacher had tied him inside a mackintosh and pulled him down the street on a chain. This teacher had often ridiculed him for his lack of proficiency in sports, and had made him feel like a 'mummy's boy'. He had not felt himself to be masculine like his schoolmates, and during the analytic hours when he was dominated by his passive fantasies he felt weak, inadequate, unmanly. To be wrapped in a mackintosh was to materialize his feminine identification: it represented his castrated state.

That the feeling of being justifiably punished and humiliated by his father was not restricted to him was evident from a memory of his fourth year, about a year before his mother's death. He recalled standing at the window of his room, to which he must have been confined for being naughty, and looking into the back garden at his mother who was beating a rug. She had looked up at him in a way that seemed both teasing and tantalizing, and he was acutely aware not only of her powerful and masterful strokes, but also of the attractiveness of his being in a confined and submissive relationship to her. This was the only memory he had of his mother being anything other than loving and tender, and its importance lay in the host of feelings and fantasies which it screened. These were largely uncovered in the analysis of his relationship to his wife, who had seemed, when he first met her, to be vivacious, teasing, seductive, and yet a powerful, knowing woman of the world in whose company he felt naïve, boyish, and helpless. During evenings with friends he would retire defeated to a corner while she kept pace with the masculine conversation. He would sulk for days without speaking, feeling that he had annoyed or displeased her; and he would sigh with relief on Monday mornings as he left for work where he could regain his feelings of masculinity. In times of passivity he thought of her as a powerful man with a penis, and of himself as being thrashed, the whip curling up his anus. Beyond the picture of his angry father humiliating and weakening him lay the fantasy of his phallic mother subjecting him to

anal intercourse. Nor was this phantasy unexciting, for in the teasing repartee which he enjoyed with his wife he invariably, and pleasurably, accepted the rôle as the teased one and so recaptured the excitement of the screen memory of his mother beating the rug. He must have often played the teasing game with his mother as a 'seduction of the aggressor' (Loewenstein, 1957).

Yet this was not the only side of his marriage. There were wonderful harmonious moments which reflected a different relationship with his mother before she died of a fulminating attack of ulcerative colitis just after his fifth birthday. His last memory of her was from the side of her hospital bed as she held out her arms to him to take him in a farewell embrace. She seemed suffused with a spiritual radiance and the aura of her delicate loveliness encompassed him with a heavenly feeling. Earlier memories were full of the tenderness which he felt from her and of the gentle and kindly love which she gave him. These feelings were recaptured in a later period of his analysis during which he eagerly anticipated the sessions in which he could find understanding and tolerance. He looked forward to nestling into the couch every day, and dreaded the final minutes before leaving. In interpretations he found strength; he fantasied sucking in my words and smacking his lips at their 'goodness'. If he arrived feeling empty, weak, and depleted, then he left feeling full, strong, and confident. On days when his work made intolerable demands on him, he would totter to the consultation room as to an oasis. There he could rely on being 'recharged', and he was never consciously aware of being afraid of exhausting me in the process or of finding there was nothing for him. On the contrary, he felt I had an inexhaustible supply of 'life-giving fluid', fantasying for example that my car never needed gasoline. However, later fantasies outside the transference revealed his fears and guilt at emptying and mutilating a loved one as he, at times, felt emptied and mutilated by others.

During these sessions he often felt sleepy but he never slept. Hypnagogic changes in his body image, of being very light and very large and of sometimes merging with me, were mildly frightening and would often be followed by a flexing of his muscles and of fantasies of running about in an excited and frenzied manner. Such motor activity, or fantasies of it, were often the expression of his joyful expansiveness in finding himself part of a larger union, but were often

also the attempt to struggle free of the enveloping merger and to reassert his own control over his muscular apparatus. These reactions, both the joy of oceanic union and the struggle against it, are typical of the state of sexual enthrallment (Parkin, 1962) which formed a major component in the emerging transference of this analysis. Underlying this state was the persisting tendency towards primary identification, originally with the omnipotent mother, which was to contribute greatly to the power of the later castration anxiety.

In the patient's early twenties he recaptured this primary relationship with a woman a few years older than himself. She was gentle and kind, and yet firmer and more sure of herself than he was of himself. In her greater maturity he found a companion with whom he could share his interest in nature, poetry, and music. He lived again the feelings he had had as a boy when, walking the countryside with a friend, he had been overcome by the beauty of the sparkling streams and the sunlit fields, and had run, joyously shouting, up and down the surrounding hills. Later when the relationship ripened to the point of their becoming engaged, he felt suddenly frightened and trapped, went away for a time to clarify his feelings toward her, and then wrote that marriage was impossible. Almost immediately he was stricken with guilt at the distress this might cause her and he wished to recover his letter. Nevertheless he was relieved to learn that in his absence she had become engaged to another. This was his only serious love affair before he met his future wife.

This meeting occurred a few years later, shortly after his bride-to-be had separated from her first husband, a somewhat brutal man. He had been moved to great sympathy by the story of her marital unhappiness and, attracted by her abandoned gaiety, vivacity, and knowing manner, began his courtship of her. After their first kiss, however, he privately examined his lips before a mirror, feeling dirty and guilty. He tried to keep their acquaintance a secret from his friends because she had not yet succeeded in obtaining a divorce from her husband. On one occasion he was embarrassed when a friend casually mentioned he had seen him with her on a previous evening. Within four months of their meeting he had developed abdominal pains, had an X-ray, and was told he had a peptic ulcer. Previous plans for moving to another city were materializing at that time, and he planned a final evening during which he intended to end their

relationship. That evening she had thrown her arms about him and told him of her love for him. He felt that what he had meant to tell was cruel, but nevertheless his fear of being trapped brought him to the point of saying good-bye. He went away for a short holiday feeling joyfully relieved, but also that he had been cruel and harsh. In the middle of the night he was struck by the conviction that he would marry her and he hurriedly returned to her to settle his plans. During the next few weeks he became increasingly confused in his feelings. At one moment he hated her as he saw her as a powerful, conniving woman of the world who was scheming to trap him: in her presence he felt weak, innocent, inadequate, not a man, 'almost homosexual'. His rescue fantasy of playing Prince Charming to her Cinderella was shattered as she no longer seemed the poor, pathetic little waif. At the next moment he was overcome with horror at the thought of abandoning her to her unhappy, solitary, miserable life and was full of sympathy and compassion for her helplessness. The vacillation in his feelings increased in tempo and he became panicky, agitated, anorexic, and sleepless. A doctor was called and he was put to bed with sedation. Shortly after, his feelings still in a turmoil, they were married.

The original basis of their acquaintance was decisive: she was the helpless unhappy woman married to a cruel brutal husband from whom he wished to rescue her. He had often thought of his parents in this way, wondering what his mother had had to submit to from his father, and remembering that his father had once musingly told him that his mother had considered him a brute. With the consummation of this oedipal rescue fantasy by way of his own marriage, he found himself once more confronted by the pre-oedipal ambivalent picture of his mother; the dreaded phallic woman and the loving tender of his physical needs.

As the conscious guilt associated with the mackintosh fantasies diminished during the analysis, other aspects of its over-determined meaning became more prominent. At times the woman who wore it appeared in radiant unspoiled beauty; beneath it was only the thinnest of dresses or nothing at all, for the tightness and smoothness of her cloak was to create the impression of a 'second skin' which would open to receive him inside. The accompanying feelings were 'oceanic' and reappeared in the transference during the already mentioned

moments when the idea of merging with the need-satisfying mother was unmistakable.

Similar fantasies appeared in richer detail, downwardly displaced by his development from a 'lap baby' to a 'knee baby' (Bateson and Mead, 1942). The open, welcoming mackintosh became a doorway to her very insides, and within her bowels he would run about in exultation. Amidst her faeces, whose presence was only dimly felt, he would arrange trapezes and swing about in free abandonment. At other times he would see himself as very small, his head coming to his mother's thighs, and reaching up under her skirts, he would push past her genitalia as through a pair of swinging doors to find himself within his favourite playground. He likened these fantasies to an incident from his later years when he had cleaned the attic of his house. Knowing it to be dirty he had stripped himself of his clothing and, pulling himself up through the trapdoor, had spent a busy but enjoyable several hours in the 'dusty dark'. His love for old and abandoned houses now came to the fore. The deep regret he felt at hearing of such a house's being torn down was one of the few ways which remained open to him for the continued mourning for his dead mother.

These phallic fantasies of penetration, regressively coloured by oral components, were not without their more frantic moments. In great excitement he would fantasy tunnelling and boring with his snout into the large woman's body, impatient to be inside. Similar feelings of frenzy sometimes occurred during my interpretations: he was so impatient to take in the good and important things I had to tell him that he was unable to keep his attention on what I was actually saying. These more frenzied fantasies became the repositories for his aggressive impulses. When he was extremely angry he would fantasy putting his fingers between the ribs of his antagonist and rending open the thoracic cage, or ripping down the abdominal wall and wrenching out the internal organs. At a time when these fantasies were as yet unconscious, they had come remarkably close to realization. As an upper school zoology student he had been known as a rough and reckless dissector, and during his term of vivisection, which he undertook in his usually vigorous way, he experienced a growing lethargy and difficulty in concentration and he began to fail in his academic work. These symptoms of a developing generalized inhibition of even those ego functions which required only a modicum of aggressive energy were accom-

panied by a more significant one: he began to suffer abdominal pains of an intestinal spastic nature. These continued intermittently over the next several years, and on one occasion he underwent a medical investigation, but no organic disorder was discovered. In the analysis these pains reoccurred following periods of anger in which his fantasies of mutilating attack were rampant. In the succeeding moments he would become afraid that he had gone too far, that his feelings might become known to his antagonist, and that then he himself would be similarly attacked in return. He would be overcome by a regressive feeling of passivity and vulnerability in which he would feel his anus to be patulous and penetrated by an arm which was painfully tugging and pulling down at his guts. At other times his fantasies were of being whipped in retaliation, with the lash curling round his perineum and up his anus, or of being tied in a mackintosh. The latter fantasies were at times accompanied by intense muscular aching. These episodes demonstrate Greenacre's observation that for the fetishist 'the body is clearly the arena of playing out fantasies and memories' (Greenacre, 1955).

In opposition to his fears of being eviscerated and of having his faeces removed there existed the contrasting fear of being prevented from evacuating his own faeces. On one occasion his child had asked to go to the bathroom while the toilet was momentarily out of order. Although to fix it would have been the work of a moment, he felt it would have been monstrous to make his child wait one minute longer than necessary, with the result that he had to remove the faeces manually from the toilet afterwards, a task not without its unconscious gratifications. It would have been the worst form of tyranny, he decried, to have made his child retain the faeces when wishing to be rid of them. He himself had often suffered greatly when he had not the opportunity for defaecation. As a child of 9 years he had lain in bed while visiting away from home, and had been too frightened to make his way down the dark hall to the toilet. (He had often lain in that bed and imagined hearing the most blood-curdling screams, doubtless the cackling of the farmyard animals outside, which he had feared were those of people being preyed upon by ghosts or vampires.) In his distress he had with his finger removed the faeces from his anus, bit by bit, and wiped them upon the wall. Here again there was instinctual gratification, both anal-erotic and anal-sadistic,

for he greatly disliked the people with whom he was staying.

During this period of his analysis he had waited one day in his car at a busy intersection for a safe opportunity to turn into the endless stream of traffic on the busy cross street. He had become aware of the growing line of cars behind him and felt that, in their impatience, he might be pushed out, like a scybalum, onto the main street and into an accident. His fears of faecal and urinary 'accidents' were particularly acute during long conversations when he felt he could not take his leave politely. Often while his wife talked to him in the evenings he would abruptly hurry to the toilet to urinate. (This behaviour was also determined by the feeling of being passively penetrated by her words and the consequent imperativeness of finding within the bathroom a haven where he could recover his masculine identity.) During an analytic hour he once expressed the difficulty of having 'so many thoughts all at once with only a small hole for all of them to come through'. In these experiences there was desire for massive evacuation (of faeces, urine, thoughts), impatience and rebelliousness against the 'tyranny' of having insufficient outlets, and the fear of endangering himself by an 'accident'. This was the way he felt when filled with terrible anger: there were not enough ways for him to get it out (though he tried, in the analysis, by shouting, kicking, and punching the air) and he was in dreadful danger of exploding if he could not. Such total suffusion with aggressive stimulation and its total discharge by all available channels has been attributed by Bak (1956) to severe disturbances during the undifferentiated phase of the drives with subsequent damage to the neutralizing functions of the ego. Greenacre (1955) similarly implicates this period of transition of dominance of the primary process to that of the secondary process.

In the episode during which he felt the danger of being pushed out into the traffic by the column of cars mounting behind, it became clear that he himself was part, in this instance the vanguard, of the faecal column. This identification of his body with faeces, those of his mother, was the result of the process of primary identification of himself with his instinctual part-objects persisting from his oceanic union with the mother to his anal-abdominal fantasies as a 'knee-baby'. This faecal identification was mobilized when he fantasied himself wrapped in a mackintosh (the abdominal 'second skin')

and, bereft of his own autonomy, become a useless 'thing', in another's power, to be disposed of carelessly and without thought that he had feelings and was alive. The mackintosh itself had distinctly faecal characteristics at times, especially if it was old and creased and crumpled: he could almost detect in its smell a faecal odour, and there was nothing that remained of its attraction.

This establishment of primary identification of his whole body with faeces was repeated, by way of the well-known equation of faeces and penis, with the fantasied faecal phallus of his mother. Faecal matters had actually played a large part in his early life. Not only had his mother died of ulcerative colitis (blood and faeces frequently accompanied one another in his fantasies) but also his father had contracted dysentery during his military career abroad and for years afterwards had frequent bouts of foul-smelling diarrhoea. He had been disgusted but impressed by the bowel performances of his father, who spoke openly of such matters, of the importance of eating the right foods, and so forth. In later years at his place of work, he had discovered in the unflushed toilet the enormous faeces of a man who he felt was gross and coarse, and he took these faeces as the sign of powerful virility. As a 10-year-old boy he had tiptoed downstairs with the faeces he had evacuated in bed wrapped within his handkerchief and had buried them in the garden with fantasies of their life-giving powers of fertilization. But those he knew best, next to his own, were the fantasied and perceived faeces of his mother. His later fantasies of phallic women were based upon the faecal phallus of his mother. So just as he, wrapped in a mackintosh, had been his mother's faeces to be expelled and thrown away, so too he was her penis (Modell, 1961). This fantasy, as Lewin (1950) remarks, 'is a denial of castration and at the same time a knee baby's downwardly displaced identification with the breast'. In the fetishist the whole body is more than ordinarily equated with the phallus (Greenacre, 1955), in this instance as a continuation of the tendency towards primary identification with instinctual objects, while at the same time serving as a defence against the enormous castration anxiety. Like a true psychological symptom, it is a compromise formation.

But just as he, wrapped in the mackintosh, became the faecal penis of his mother, so did the woman, when similarly wrapped, become *his* penis. Only over such a woman did he feel

absolute control. There was no need for the continuing adaptation to his partner's expectations so necessary for her transformation into a cooperative partner. This 'work of conquest', as Balint (1948) has described it in his characterization of genital love, was rendered unnecessary on his part by the conquering fetish. Wrapped in the smooth and shiny mackintosh she was in his power, and thus clothed, not only did she stabilize and reinforce his own genital functioning (Greenacre, 1955) by becoming his penis but also she became the receptive aphallic woman who did not arouse his anal passivity as did the phallic woman (Garma, 1956). Thus the fetish represented the maternal phallus only when he himself wore it. When it was worn by the woman she became receptive and castrated, a fact which he could tolerate only by its making of her, at the same time, his own penis. The bisexual meaning of the fetish has been noted by Balint (1935) on different grounds and re-asserted by others (Greenacre, 1953).

The capacity of the mackintosh to represent the castrated state derived partially from its essential smoothness and shininess, which he compared to the circumcised glans penis. He had been circumcised as a child, though he had no memory of it. A screen memory from his early years, however, which condensed many other themes, contained this one too. He recalled watching a funeral procession either from the side of the road or through a crack in the window curtains of a house across the street. He was aware of a feeling that the scene was a forbidden one and that he should not have been watching. Someone was holding a baby, red and 'skinned' in appearance, but it was not clear whether it was this infant that was being mourned. The sight of the baby horrified him, as did the cold unfeeling words of his father, whom he overheard dispassionately discussing the event with another man.

This memory condensed the sight from the side of the road of his mother's funeral procession; his furtive view of the primal scene ('through the curtains') with its sadistic, even fatal, consequences and the sight of his father's large penis: and the experience of his own penis being 'skinned' while his father dispassionately discussed the operation in his presence with the doctor. The memory may very well have screened the sight of some other mutilating operation, as Greenacre (1953) has suggested as being of significance in the early history of the fetishist—perhaps the sight of a bloody

faecal evacuation of his mother—but this could not be reconstructed with any certainty. However, the reconstructed view of his father's impressive penis provided the experience around which had crystallized so much of his attitude of enthrallment towards idealized and potent men in his life, and crucially in the transference. His wish to incorporate the enthralling penis, which he had had for that of his father, was continuously repeated in the transference and also appeared as the wish to incorporate the analyst completely, my whole body having become equated with the penis as had his own. The retrospective attribution of the penis to his mother was not only out of defence against the possibility of castration, but also out of the fact that his original enthrallment had been with his omnipotent and gratifying mother.

His own identification with the penis was manifested in a dream of standing in a puddle of his own urine, a dream which had occurred after having had intercourse the previous evening with the thought that, having just urinated, he might have introduced a few drops of urine into the vagina and his own penis might, in fact, be 'standing' in his own urine. His wish to incorporate me, as equated with the penis, which produced his own identification with that organ, was often accompanied by feelings of being a 'wind tunnel' which would suck me out of my chair, and was followed by feelings of rising off the couch, of defying gravity and floating in space, which were the original sensations in his own tumescent penis.

Thus for the fetishist, as has been pointed out by both Payne (1939) and Bak (1953), the mackintosh condenses all the significant instinctual part-objects of the prephallic years: (a) the breast with which he unites, (b) the abdominal skin which he penetrates, (c) the maternal faeces with which he identifies. Finally, it transforms the one who wears it into the phallus of another while at the same time revealing his or her own castrated state. Thus the mother is seen as both phallic and aphyallic, and the two identifications with her, existing as they do side by side, contribute to the characteristic split of the ego (Bak, 1953). Gillespie (1952) similarly implicates the identification with the aphyallic woman, although from a different point of view, in contributing to the ego split. This double view of the mother as both phallic and aphyallic not only heightens the later castration anxiety (insofar as he has already identified himself with the castrated mother) but provides

an irresistible introduction to the inverted oedipal relationship with the father (insofar as he has already adopted a passive anal relationship with the phallic mother) which becomes, characteristically, one of sexual enthrallment (Parkin, 1962).

During the course of the analysis, there was a constant shifting between these two identifications which was usually slow and subtle but could be often extremely rapid and pronounced. Thus, one session began with a dream in which he had felt his wife to be behaving in a potently virile manner towards him. The dream was followed by fantasies of being tortured and mutilated by several men, one at his hands, one at his head and nose, another at his abdomen, another at his genitalia and perineum, and another at his legs. He pictured himself tied in a mackintosh, felt extremely tense, and complained of a violent aching in all his muscles. This then gave way to a shuddering which he described as 'one-quarter delicious and three-quarters revolting'. The shuddering movements quickly became vigorous flexions and extensions of his arms and legs, and he began to punch the air about him and to 'pedal' with his legs above his head. He felt himself becoming more and more violent, and fantasied propelling himself off the couch as by a jet, and through the end wall, leaving a hole in the shape of his body with its outflung limbs. He compared himself to his powerful and violent father, and imagined that his mother also must have experienced the latter in this way. In spite of his activity on the couch he was aware at every moment of my presence, which he felt to be that of a rather interested observer. Such experiences led to the reconstruction of the memory of himself as the interested observer of the primal scene in which he first identified with the passive castrated mother and then, out of fear of the mutilating consequences, with the violently active father. (There was opportunity later to interpret the residues in the dream which derived from the evening before with his wife and which had precipitated the events of this session.)

The following day he reported a dream of the preceding night: 'You are living in an exclusive part of town and leading a fast life—having intercourse with many women, the wives of other men who live in the district. I look in the window of your house and see you having intercourse with a woman who is not your wife. I am bitterly disappointed in psycho-analysis.' Here, following the reconstruction of the previous

day, was a clearer representation of his observation of the primal scene which permitted a further interpretation to include his feelings of being shut out from the exclusive company of his parents, of envy at the potency of his father, and of disappointment in his father's faithlessness to himself.

Feelings of being unwanted and excluded from the company of those he considered more masculine than himself formed a constant theme, especially within the transference. He was envious of every new object he observed within the consultation room and felt that each one placed me more and more beyond his reach. Accompanying this theme, like a counterpoint, were his unconscious attempts to manoeuvre his wife and me into a relationship in which he could be the child; this came to form a strong resistance. In these attempts his wife was placed in the rôle of his father and I in that of his mother. He would complain at length of how badly he was treated by her and be ready to construe any remark of mine as a disapproval of her unjustified attitude and as a championing of his cause. He wished at this point to retire from the scene and leave the arena of battle to his wife and me. These feelings became conscious only when it became clear that he was behaving in a complementary manner at home, that he was in subtle ways representing me as the aggressive father who demanded that he become more assertive with his wife. Frequent interpretations were necessary to alleviate this acting out which also had the defensive function of relieving him of any responsibility, and hence guilt, for relinquishing his passivity in his relationship to his wife.

In spite of his resentment of the distance he felt between himself and those he imagined to be his superiors, he was clearly reluctant to accept any gesture on the others' part which might indicate their equality. He could always find some reason to regard the other as superior and to give himself cause for envy. He could not tolerate any 'equalizing' remark from me without feeling that I was patronizing him or trying in some way to use him for my own purposes. He seemed determined to maintain his rôle as underdog. And yet all the while he would be preoccupying himself with fantasies of how to turn the tables by a sudden *coup*. He said of himself that if his chief were to offer him his own post he would have to refuse it and await the success of plans to overthrow him. He felt himself to be a plotting revolutionary, but

one who was in constant danger of being discovered and 'sent to Siberia'.

He was extremely sensitive to the movement of international events, and especially to those emanating from Russia. He felt that the West was decaying through excessively luxurious living, and was reminded of his father's enjoinders to avoid any semblance of self-pampering 'lest the stock die out'. A Russian intercontinental ballistic missile would be no more than we deserved. During a period of Western initiative he apprehensively awaited the Russian counterblow: 'Now they'll be up my arse-hole'. At the same time he stoutly and vociferously supported the action of the West as defensive, but revealed his aggressive feelings through his identification with the officer who reputedly promised 'to democratize these people if I have to shoot every last one'. But with it all he felt he was only a small boy standing on the sidelines shouting incitements to the antagonists, who would flee for his life if one of them so much as looked his way.

He was deeply ashamed of what he felt to be cowardice in such situations and believed that he would not be able to tolerate the least amount of pain before pleading for mercy. In actual situations of pain he was distressed much more greatly by the fantasies which were consequently stimulated. While having a tooth pulled he imagined his lower jaw was being torn from his face. How terrible this would be, deprived of all ability to talk or to communicate with others: he would be just a thing, a useless object, ready to be cast aside. He recalled seeing a man a few weeks previously whose face had been thinly bandaged. Through the cloth he could see that there was no nose, only a hole, and he was filled with horror. He could tolerate the loss of an arm or a leg—could not a prosthesis be obtained?—but not some part of himself which was so essential to his identity. He felt old, exhausted, used up, ready for the garbage heap, and the next day he had to remain away from work. During that morning he watched, on television, a master of ceremonies entertain an audience of women, and wondered in amazement how a man could tolerate spending his working hours so frivolously in the company of women and still maintain his self-respect as a man. He was afraid that I would reprimand him for shirking his job unmanfully and he was eager to be back at work.

The feeling of being castrated, the horror of having only a hole and of the loss of his identity,

was almost continually present. More often this feeling was expressed in anally regressive terms in which his phallus was represented by the 'live' faeces within himself, and his useless castrated body by the 'dead' faeces outside. Those who made demands on him greater than he felt he could meet depleted him, made him feel weak and unmanly. He would refer to them as 'the shit diggers', and they included his creditors who wanted his money, his subordinates who wanted his knowledge, and his wife who wanted his time. That the process of being 'dug' was not altogether unpleasurable revealed itself in the facility with which he became a debtor and in the readiness with which he placed himself under another's domination. But after a demanding day at work or evening at home he would feel empty, dead, and useless. In contrast to the faecal language in which he so frequently expressed himself, the oral aggressive themes had to be reconstructed more completely. The penis that was amputated and the faeces that were removed also represented the sustaining breast that was withdrawn. The 'oral' atmosphere which he sometimes created in the analysis has already been mentioned. With his wife he was disappointed in the smallness of her breasts, but nevertheless, and even though she was often the one who depleted him, he would look forward at the end of a tiring day to nestling into her at night and 'recharging' himself for the morning.

The anal regression and the anal and motor sadism in the fetishist have been emphasized by Bak (1953) and Greenacre (1953), while Gillespie (1952) has stressed the partial regression to the oral-sadistic stage. Instinctual derivatives from all these pre-phallic periods were prominent in this patient and coloured in a distinctive way the phallic period with its associated Oedipus and

castration complexes. However, the significant manner of the development of his object-relations was the persisting tendency toward primary identifications dating from the period of earliest infancy. This predisposition to regression from object-relationship to primary identification, directly manifested in the fluctuation of body image and of boundaries between self and not-self, precipitates anxiety of bodily dissolution which, because of the establishment of the equation between the body and the penis, impairs the sense of integrity of actual penis and contributes enormously to the development of castration anxiety. The opinion of Socarides (1960), that the unresolved wish in the male to give birth to a child is of importance in the development of the particular form of fetishism which he describes, would seem to be one of many possible ways in which the fundamental anxiety of bodily change may be activated.

Finally, it should be noted that emphasis on the importance of persisting primary identifications in fetishism links with the observations of Winnicott (1953) on transitional objects. His reconstructions on the rôle of these objects in the process of the differentiation of the self from the non-self makes it clear that a too long continued maternal adaptation to the needs of the infant may lead to a persisting primary identification and accentuation of the role of the transitional object or related phenomena. A fetish may thus be regarded as an object which possesses the dynamic significance of transitional phenomena, which recapitulates and condenses the pre-oedipal object choices, and which acts in the service of defence against the anxieties characteristic of the phallic period to which it owes its final and definitive form.

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RELATIONS BETWEEN PSYCHO-ANALYSTS¹

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I feel that the best way to begin this study is to go back, for a brief moment, to the first period in the history of the psycho-analytic movement, not only for the sake of preserving chronological order, but also, and more basically, because of the great significance and the repercussions of the conflicts and disagreements that sprang up between Freud and some of his first disciples. Freud himself (1914, 1925, 1937) refers frequently in his writings to these painful events in his life.

Perhaps it was the influence of these distressing experiences that led him, years later, to postulate (Freud, 1937) that not all analysts have attained the degree of psychic normality that they would like for their patients. He adds that, unfortunately, training analysis does not ensure that the modifications brought about in the ego will last. He compares the practice of psycho-analysis with the possible effects of X-rays when used without proper precautions. He refers to the 'dangers of analysis', which threaten not only the passive participant in the analytic situation (the patient), but also the active one (the analyst), by exposing him to the reactivation of his own instinctive drives. He proposes, as an adequate preventive measure, that every analyst should undergo analysis periodically, say every five years. Among the authors who have dealt with this problem I may mention Balint (1948), Thompson (1958), Menninger (1942), Rickman (1951), Waelder (1955), and Langer (1948).

I shall now examine some of the factors inherent in the nature of analytic practice that, to my mind, are very important causal agents in many of the tense conflict-situations that arise between analysts. Any analyst will necessarily and inevitably meet in the course of his career with conflict-situations, many of which arise from his scientific and social connexions with his colleagues. Theoretically he should be able to

tolerate them and cope with them, at least to the same degree as he expects his patients to do with their own conflicts.

Yet we all know, to our regret, that this is not the case. My main endeavour will be to try to point out the causes and motivations that underlie this unhappy circumstance, as a first step in our efforts to remove them. It has been argued that at their beginnings the various analytic groups had sharper and more serious conflicts, since they were small, closed, family nuclei. But this is only partially true, and the statement loses some of its cogency if we turn our attention to what happens in larger and more developed groups. Here the members are not in such close contact, yet they suffer from difficulties of like quality and intensity, even though there may be shades of difference.

Do the conflicts that may arise among analysts differ in essence and quality from those arising in any kind of group? Some will maintain that the nature of the relations concerned is exactly the same, and therefore the disturbances that may affect them cannot be very different. It seems to me a mistake to minimize the differences between the dynamics of a psycho-analytic circle and those of any other scientific, social, or working group. There are certain specific attributes in the activity of analysts that bestow a specific quality on the content and expression of the conflict-situations that arise between them.

The first of these is the analyst's own analysis. This involves, from the outset, a differential characteristic of prime importance as compared with what occurs in other groups. Another factor concerns his professional activity. We should recall what Freud (1937) said about the painful obligations an analyst must comply with in his daily work.

The 'dangers of analysis' mentioned by Freud refer to the possibility of awakening

¹ Summarized version of a paper presented as an opening report before the Third Latin-American Psycho-Analytical Congress, Santiago de Chile, January, 1960.

instinctive urges, which may have a harmful influence on the analyst's personality because they cannot find an adequate mode of discharge with his patients. At times, in a displaced form—and leading to acting-out—the analyst unconsciously chooses a target for discharge. This target is his colleagues, as he unconsciously feels them to be a legitimate justification for exteriorizing his reaction. But, I think, something further must be added to this mechanism, and that is the weight the analyst feels he must bear in consequence of what his patient deposits in him, by means of multiple and successive projective identifications. This means that it is not only a question of enduring his own conflicts, reactivated by the impact of transference vicissitudes, but also the various conflictual situations his patients project into him, which continue to weigh upon him as their depository.

In previous papers (1958, 1962) I have been concerned with the importance, from a technical point of view, of taking into consideration the effects of *projective counter-identification*, as I have called the specific partial aspect of counter-transference determined by the patient's excessive use of projective identification.

Acting-out also arises, on occasion, from the need to 'change' the idealized position in which patients are accustomed to place the analyst on account of the screen quality he possesses for them. We all know that, even though we tend systematically to reject and interpret this idealization, it is sometimes difficult not to submit to it. Thus, for instance, one may hide from the analysand some illness or important happening in one's private life that entails a temporary interruption of the analysis. We cannot afford to fall ill, lest we foster the fantasies or modify the idealized image of us the patient has built up. But the analyst may also feel that he must maintain this ideal of health and perfection even in the face of his colleagues, trying to avoid possible criticisms and the exploitation of these 'flaws'. Some analysts will then seek refuge, pathologically, in the apparent 'humanization'² achieved through their acting. Paradoxically, they will try to claim for themselves as well the right to be neurotic and not to be invulnerable embodiments of health. But I think the analyst's acting out is also a consequence of his difficulties in working-through anxieties increased, as we shall see later, by his isolation and regression. In this respect,

acting would tend to dramatize those aspects of his conflict which he feels to be most acute or pressing.

I shall now speak of some of the factors I consider of first importance in fostering many of the difficult or negative aspects of the relations between analysts. These are those concerning the analyst's isolation and deficiency of ordinary communication with others.

Owing to the nature of his activity, the analyst spends most of the day isolated in his room. Not only does he feel cut off from the rest of the world during relatively long periods of his daily life, but also, for reasons peculiar to his work, he is reduced to a minimum of opportunities for communication with others.

To this we must add the almost inevitable consequences that follow from the specific features of analytic work and its technique. If we accept that in every analytic situation there arises from the very beginning, and almost automatically, a regression in the patient, largely determined by the atmosphere or by environmental influence, then we cannot deny that the analyst himself is scarcely able to escape from this *regression*. Furthermore, analytic work requires the analyst to be 'in connexion' and 'communication' with the patient in order to apprehend what is deep and latent in his material. But this type of communication, even in the best of cases, is but partial and of a very particular quality. The analyst is fulfilling a role that involves certain features to which he must invariably and rather strictly adhere; that is to say, he must confine himself exclusively to interpreting the material offered by the analysand. He must not converse with him, still less express any thoughts, ideas, or feelings that concern his private or professional life but are foreign to the patient's interest. Even when his reactions happen to be related to the analysand (all that is implicit in the counter-transference panorama), only very seldom will he be permitted to transmit them to him. Thus his communication will always be *partial* and *dissociated*: he only intervenes actively with the professional or analytic part of himself, while the rest must remain denied, controlled, suppressed. If it happens otherwise, if his attention wanders and he withdraws to 'communicate' through his thoughts with the 'outside', guilt-feelings arise, a technical problem ensues, and the need to

² Gitelson (1962) touches on this aspect of the analyst's 'humanization'.

break or cut off this 'communicative flight' with the exterior is carried through. The analyst, to a certain extent, is in a situation of isolation, regression, frustration, dissociation, and other well-known phenomena—reactivation of anxieties, exacerbation of conflict remnants never totally overcome; and having to bear tensions projected on him, without sufficient discharge of increased instinctive urges. In consequence of all this, many situations or aspects conveyed in the schizoid-paranoid position tend to become more acute: persecutory anxieties are strengthened; reactions of rivalry, envy, and competition are intensified.

The particular conditions and circumstances under which analytic work proceeds undoubtedly determine an important privation of informative data and stimuli (with the single exception of the material the patient supplies).

This provokes at times a particular greed for the supply of external stimuli, and this explains, in such cases, the great attention the training analyst pays to the candidates during the control sessions, because for him they signify, on occasion, a real safety-valve offering him the social contact he desires.

Here, however, I feel it is in place to make some further remarks, for there are several implications involved in the process of control with candidates. As a rule, in view of what has been stated above, the analyst tends to behave in a more active and communicative manner with candidates coming for control than with his own analysands. This is obvious enough, and would not deserve mention, if it were not for the fact that this aspect of the two-person analyst-candidate relationship contains some special elements. For instance, in the analyst's fantasy the candidate may stand for another analyst belonging to a rival group. It will sometimes be hard for him to avoid feeling passively inclined to want to know and inquire what is going on in the 'outside', with the other analysts, especially if the events he wishes to learn about have some direct or indirect connexion with himself.

Another manifestation of the avidity for stimuli is related to the *genesis of rumours* and their psychopathology—in our circle, at least. Whoever spreads a rumour is seeking to satisfy that part of himself that is eager to learn of current events and, by adding to it some elements from his own fantasy, he strives after a certain omnipotent control of the external situation from which he feels excluded.

In the paranoid content of his reaction there is

the feeling of having been left out of certain subgroups, and he has to prove to himself and to others that this does not affect him but that, on the contrary, he is up-to-date with all that goes on behind the scenes. Just as in the child there is an attempt to supplement with his fantasy and omnipotence his feeling of exclusion from the primal scene, so I consider that a similar process very often occurs in the adult. Moreover, owing to the setting of isolation and regression in which the analyst carries on his work, and through the increment of his paranoid anxieties, he will unconsciously feel that all those whom, as they are not present with him, he cannot control, are automatically and permanently living the primal scene. The one who receives the rumour, although he participates in a passive manner, presents similar mechanisms. He at once forms an alliance with his informer against the common enemy who has excluded them.

Another of the ways in which the analyst defends himself against his feelings of loneliness and privation is by resorting to his *fantasies of omnipotence and denial*. It is to combat his feeling of loneliness and his anxieties, among other reasons, that the analyst feels the need of belonging to some group. His ego requires to be strengthened and enlarged by other egos who will offer him support, who will share many of his preoccupations and give him reassurance, albeit indirect, in moments of anxiety or weakness. Naturally enough, besides this need there are other more authentic and valid reasons. The advantages of being together to study and explore certain problems, to discuss and exchange ideas, to investigate and develop theories, etc., are grounds so real, solid, and positive that they do not require the support of further argumentation. I will only refer here to one of the motives for forming groups that is not always fully conscious to their members. Besides, even though in the heart of the subgroup conflicts similar to those of the large group may arise at any time or exist in latent form, it will be easier to set them aside or counteract them by the well-known mechanism of the common enemy or persecutor placed outside.

I believe that one often requires that a certain ideology should be shared by others as an adequate form of reassurance. At other times, in so far as a certain ideology signifies an aspect of oneself, e.g. the good inner object that must be preserved, one seeks to contact those who share it so as to make up a strong group

able to face those who maintain a different ideology.

It happens at times that the reaction to the reactivation of anxieties for the reasons described may be just the opposite. Instead of seeking the company of others, one tends towards *solitude*. There may have been, at first, a feeling of frustration and disappointment that is added to the persecutory experience: the predominant emotions are rage, indignation, a feeling of having been betrayed, etc.; then finally the defensive response of withdrawal, of uniting with the idealized inner object and cutting off communication with others. One thinks that all the good is in oneself and one has no need of the others; one tries to prove that one can get along very well—or even better—without them, and one trusts that the final victory will prove one right.³ Secretly one hopes for reinstatement and indemnification for the unfair treatment and exclusion.

Privation and isolation will bring about an increase in the feelings of envy and rivalry which may pre-exist for various reasons. Klein's work (1957) suggests that the first envied object is the nourishing breast. This primitive envy is, in a sense, revived by the analyst during his seclusion, and unless it is counterbalanced by feelings of another type, it will invade his fantasies, giving them an aggressive content and directing them against his colleagues and their sundry activities: analyses, lectures, seminars, scientific papers, etc.

Denial and idealization will be utilized as more effective defences against persecution and envy. To these must be added *dissociation* as a means of preserving the good and idealized objects from the persecutory objects onto whom one has projected one's own capacity for aggression and destruction. This may be reflected, for example, in the analyst, in his seeking to relate himself with certain persons or groups with whose technical or theoretical principles he feels affinity, so that they thus become depositaries of what he has idealized. Then he will necessarily place all that is evil or persecutory in the rival persons or groups, from whom he will try at all costs to keep separate so as to avoid the danger of the resulting integration and reintroduction of the rejected aspects.

I will deal briefly with another important motivation, of particular significance, closely bound up with some of the feelings mentioned

above. *Guilt* felt by the analyst about his work may lead to reactions of various kinds. I refer here to the feeling caused by the experience of having failed in his need to make reparation, and finding himself unable to cure his patient as he had hoped. Under such circumstances it may happen that the analyst falls into a frank depression, or submits masochistically to the criticism of his superego and assumes attitudes that may well cause him serious difficulties in his relations. On other occasions there will be a denial of his own guilt and its projection onto others whom he will criticize, at times harshly, for errors of technique that he ascribes to them or for theoretical concepts he deems erroneous. He will tend to underrate the activity and production of others, not only to defend himself against envy, but also to free himself from his own feeling of self-devaluation caused by his guilt feelings.

I must make it clear that I am deliberately leaving aside the whole of the positive and gratifying aspects of our work: all it implies as an expression of life, the capacity for sublimation, and the possibility of satisfying our reparative impulses. I am only concerned here with some of the conditions under which we perform our task, which, when they are present too intensely or too continuously, may produce negative effects. And though I have especially stressed the conflicting aspects of the relations between analysts, with the intention of pointing out some of their motivations and thus contributing to their elimination, this does not in the least mean that I deny the existence of good relations. I consider, on the contrary, without thereby implying any contradiction, that manifestations of solidarity, sympathetic understanding, comradeship, and loyalty are both frequent and profound.

Freud described the happiness of feeding at the breast as the prototype of sexual gratification. According to Klein (1957) this experience is the basis not only of sexual gratification but of all later happiness, and makes possible the feeling of unity with someone else: such unity means being fully understood, a fact that is essential in every friendship or happy love-relationship. From this standpoint, drawing the corresponding parallel, I would say that it is not enough to know that one's analysis has been sufficiently long, since one is interested in its quality also. If one feels one has been well 'breast-fed' by one's analyst, with ample

³ Not to be confused with the capacity to be *alone*, as set forth by Winnicott (1958), where he explains the positive aspect of this situation.

gratification, there will be firm soil for feelings of gratitude, and consequently one will achieve better relations with other people.

Klein (1940) has particularly insisted on this aspect, pointing out that the experience of possessing a good inner object increases gratitude, which in its turn is closely connected with generosity. There is a feeling of inner wealth, and the subject feels able to share his gifts with others.

I have referred above to the need of suggesting possible solutions to improve our relations. It seems to me that one effective method, among others, would be to keep to certain rules of 'mental hygiene' which are of the highest preventive value. Thus, for example, I feel that, in view of the nature of our professional work in the senses referred to above, we ought to devote fewer hours to work with our patients under the present conditions. This would be not only to our own benefit but also to theirs. Furthermore, it would be advantageous up to a certain point to have greater contact and communication with the 'outside' of the analytic world. A gradual trend in this direction has been visible lately among our members, several of whom have been devoting themselves to courses, lectures, professorial chairs, hospital work, etc.

It is my belief that in most of us there is a lack in our capacity to integrate our work with the various spheres of culture, science and art, in moments of expansion, and, last but not least, in the time we devote to our family life. We feel, at times, that our work absorbs our energies in an absolute and inexorable way. But we cannot deceive ourselves; we well know—as we should interpret to any analysand—that we allow ourselves to be absorbed, among other reasons, because it pleases us, because it gratifies many of our unconscious aspirations and impulses. But how often do we lament and complain that we cannot find time enough for all the things we would like to do! Time then becomes our implacable persecutor, to whom we submit with all kinds of rationalizations.

I am aware that the problem is far more complex and cannot be rounded off so easily as I am doing. I shall confine myself to enumerating some of the reasons implicit in its genesis:

narcissistic satisfaction; the need to build up, maintain or increase our prestige; rivalry and envy; the search for refuge in hard work so as to elude other conflicts; real or fantasied financial necessity; genuine gratifications; etc., etc. The most likely thing is, of course, that several of these motivations appear in combination, in varying proportions.

The important thing is to find where to draw the line, and a just measure to apply on every level of activity. If we claim a better life for our patients, it is only natural that we should allow ourselves to live better too and satisfy our own needs more fully.

Summary

This paper deals with the vicissitudes in the relations between psycho-analysts and with their motivations. In the first place it attempts to define the differences that exist between the dynamics of the relations within a group of analysts and those within any other scientific, social, or working group. It then refers to the specific characteristics of the profession, for the activity of analysts bestows a certain specific content and expression on the conflict situations they have to face. Next, it analyses some of the factors bearing on the determination of these specific aspects and their consequences: isolation, lack of communication (necessarily partial and dissociated), and a certain degree of regression. All these, added to the predisposing elements in each personality, may lead, on occasion, to the intensification of persecutory anxieties, with the utilization of schizo-paranoid mechanisms and increased reactions of rivalry, envy, resentment, or fear towards those who represent re-editions of past persecutory imagos. These states and mechanisms will also be of influence in the need felt to form part of subgroups with common ideologies and affinities so as to reinforce our defences and to strengthen and amplify the ego. Nevertheless, it is also as a result of the working-through of the depressive aspects, with a reparatory content, that one acquires feelings of solidarity with others, by receiving or imparting knowledge, by exchanging positive sentiments and emotions, and so fostering good relations.

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A NOTE ON NON-PAYMENT OF PSYCHIATRIC FEES

By

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When a patient in psychotherapy fails to pay his bill, he has violated an explicit and agreed responsibility. In an effort to gain some understanding of the dynamics of this problem I have reviewed all instances in my private practice in which it has arisen. I have found that the proportion of debt-beaters (or 'deadbeats') has remained stable over the years at about one patient in seven (36 out of 242 consecutive cases seen in the last six years). Since other difficulties in the conduct of psychotherapy, such as patients quitting treatment, have gradually diminished in frequency as I have gained experience (Gedo, 1959), the continued occurrence of the non-payment problem suggests that some particular characteristic of these patients is the principal independent variable involved.

Closer study of my cases reveals that non-payment was frequent when someone other than the patient was responsible for the bill. Since I have no information about the motives of these individuals, this report will exclude such cases. When this is done, the remaining patients display a remarkable consistency in their psychopathology; none was schizophrenic, none was overtly depressed; *all* these patients had come for help because they had been depressed or presented various complex defences against experiencing affective disturbances.

One prototypical case report follows:

A 48-year-old commercial artist sought psychotherapy because he could not moderate his hostility towards men. He gave a history of severe competitive conflicts with a cold, authoritarian father and an older brother; he had great difficulty in discussing his mother in any way, but conveyed that he had had little contact with her. Once-a-week therapy was begun, and the patient's initial difficulty in talking gradually subsided. He showed some reluctance to pay my bill after the second month of therapy, but this was well rationalized behind 'realistic' considerations. He decided to pay for each hour at its conclusion, and I was unable to get him to

consider his motivation for doing so. In this way he began to owe me for something over one month's appointments. He made vague allusions to feeling that his wife did not care enough about him. He came to realize that he was more comfortable with me if he could fight me (as he had fought his father), and that his fights with men had always been such defensive displacements from the real issues—at the time, his marital conflicts. This enabled him to discuss his dissatisfaction with his wife's frigidity. Meanwhile, a pattern of retaliative silence on his part emerged in the hours at the conclusion of which he knew I would hand him my bill (for the unpaid balance from the early months of the therapy). In the other hours, however, he was able to tell me of his sadistic sexual fantasies concerning women.

After about eight months of treatment there was a marked improvement in his original complaint. He had a mild financial crisis at this point, and was very gratified about my willingness to extend him some credit. He had a mild transient paranoid response, however, to this gratification of his passive longings. He was able to verbalize how he suffered a loss of self-esteem by being in such an 'inferior' position. His attempts at overcompensation (e.g. dangerous driving) brought him into conflict with fears of retaliation by men. Gradually he became bolder in acting out his competitiveness with me in the sessions, and he was also more tolerant of his desires for being taken care of by me. He became increasingly concerned about his finances, and contrived to produce a real crisis in them by neglecting his business. When I indicated that I was unwilling to continue the therapy without payment by an agreed date he decided to interrupt treatment. He returned in a panic about a month later, demanding hospitalization. This turned out to be the result of his anger over my refusal to care for him unconditionally. Although he was able to obtain a well-paid job almost immediately, he

decided against resuming therapy (allegedly for financial reasons) and made no payment until he returned several months later. At this time he forgot to bring the cheque he had written. He had become severely addicted to alcohol, and had to be hospitalized for some time to deal with this. He has never returned to see me, but has responded with a token payment on his unpaid bill at 3-4 month intervals. At the present rate it would take about 20 years to complete payment.

Discussion

In reviewing the meagre psychiatric literature on the problem of fees in general, I found nothing pertinent to the subject of non-payment—except, perhaps, Freud's original warning (Freud, 1913):

'The analyst is . . . determined from the first not to fall in with this attitude (of inconsistency, prudishness, and hypocrisy), but, in his dealings with his patients, to treat of money matters with the same matter-of-course frankness to which he wishes to educate them in things relating to sexual life . . . Ordinary good sense cautions him, furthermore, not to allow large sums of money to accumulate, but to ask for payment at fairly short regular intervals—monthly, perhaps.'

It is this hiatus which impels me to set down explicitly a set of conclusions which are perhaps self-evident to those who are familiar with recent psycho-analytic concepts of delinquency. Before proceeding to summarize these theoretical considerations, I want to draw attention to a neglected clinical contribution by Blitzsten (1936) in which he described a type of personality he called 'fraudulent character' in which depressive moods are prominent. Blitzsten carefully differentiated these patients from cyclothymic personalities, calling attention to the aggressive and manipulative aspects of their depressive moods and to the absence of the mechanism of turning hostility against the self. He noted that 'To get something for nothing and to be the only one receiving care without cost are characteristic of these persons', and he mentioned that this behaviour is on the borderline between the volitional and the uncontrollable. He emphasized 'the unwillingness to take on any of the responsibilities and conformities of adult social life . . . [in analysis these] patients often seek

actively for types of dependence and irresponsibility they have not previously been able to achieve.'

In my experience, it is precisely these patients who become 'deadbeats'.

Delinquency used as a defence against object loss has been described in children by Ruben (1957). She has noted three main dynamic trends which fuse in the symptom of stealing:

- (i) 'identification with the sadistic "robbing" mother who has deprived the child of the possession of his first love . . . and has thus instigated his revengeful hostility.
- (ii) 'provocation of punishment which in turn led to unconsciously desired passivity.
- (iii) 'regression and clinging to a transitional object—an attempt to magically incorporate mother's love via an inanimate object.'

Ruben explains this last statement further:

'In times of stress, older children fall back on a transitional object by cathecting [a thing] again with all those qualities which belong to the conception of an infant's psychic world.'

The concept of transitional objects and transitional phenomena was introduced by Winnicott (1953). I believe that the withholding of payment for psychotherapy is best explained in this conceptual framework. Winnicott defines as 'transitional' the intermediate area of experience between thumb (the 'me') and teddy-bear (the 'not me'), between oral erotism and true object relations, between 'primary unawareness of indebtedness and its acknowledgement'. The things and experiences comprised under this rubric (e.g. a blanket; the act of babbling) become essential somewhere between the ages of four months and one year as defences against separation anxiety. The transitional is neither internal nor external; it is not the breast, but it stands for the breast. It may eventually develop into a fetish and so persist as a characteristic of adult sexual life. (Note in this connexion the views of Schmitzberg (1956) who calls delinquency a type of perversion and stolen objects fetishes.) Normally, however, the transitional phenomenon becomes

'spread out over the whole intermediate territory between "inner psychic reality" and the external world as perceived by two persons in common', (Winnicott, 1953).

i.e., it loses its special meaning. The need for a *specific* object or behaviour pattern may reappear, however, under later threats of deprivation, Winnicott says,

'thieving can be described in terms of an individual's unconscious urge to bridge a gap in continuity of experience in respect of a transitional object.'

He also offers a clue about the probable genetic determinants of the syndrome we are considering in discussing the ideal of development in this respect: a 'good mother' begins by allowing the infant to have the illusion that her breast is part of him and later *gradually* disillusion him:

'An infant can employ a transitional object when the internal object is alive and real and good enough (i.e. not too persecutory). This internal object depends for its qualities on the existence and aliveness and behaviour of the external object.'

I believe this is tantamount to saying that neither schizophrenics (whose objects are missing) nor depressives (whose objects are 'bad') are likely to be 'deadbeats' (i.e. to regress to the use of a transitional object). In this group of patients personality organization is reminiscent of that of young children. Like Spitz's (1946) cases of anaclitic depression, their distress was relieved when they were offered a consistent external object in the therapy, but the maintenance of the internalized representation of this object depended on the illusion of symbiosis. When disillusioned by reality, these patients used the transitional phenomenon of withholding payment to deny their separateness.

Kaufman (1960) puts the matter in this way:

'Delinquent children belong to the pre-oedipal, pregenital, impulse-ridden group . . . Regardless of their chronological age, they have not really entered the phallic-urethral stage . . . During the course of therapy they regularly express and act out their concern over object loss. [They] talk about feeling responsible for a misfortune [but] may be expressing omnipotent feelings rather than guilt . . . Children interpret pathologic and repeated object losses as hostile and sadistic actions; [they] incorporate this sadomasochistic way of relating to the world . . . Projective mechanisms appear to serve the purpose of denying any affective awareness of loss.'

The presence (or absence) of these projective mechanisms distinguished one end from the other of the spectrum of my non-paying patients. On the one hand, there were those who did not deny their indebtedness but maintained an unpaid debt as a way of ensuring regular communication with me after formal therapy came to an end. Some of these patients were adolescents cut off from family ties who needed a lifeline to an interested adult. There was never any doubt of their intention to pay or of their positive feelings about the therapeutic experience. The most illustrative example of such a patient comes not from my own practice; I am indebted to Dr Leroy Levitt who used it in a discussion of this paper: an octogenarian who was afraid of imminent death offered to pay a psychiatrist for a year's treatment *in advance*, clearly as a magical reassurance against object loss.

At the opposite extreme, there are patients who use paranoid defences to justify their retaliative withholding of the psychiatrist's fee. Often they go through complex manoeuvres to prove to themselves that the therapist is bad and should be attacked with righteousness. These are the most difficult cases to deal with in a rational and non-punitive manner. It is precisely the denial of his helpfulness which is most threatening to a physician and is likely to arouse acting out on his part. (McLaughlin, 1961).

This is not intended to suggest that realistic measures to collect one's fee (including legal action, if necessary) are ever contraindicated. However, even these measures can be conducted in a therapeutic manner rather than in a spirit of vengefulness. In this connexion, it should be mentioned that in those cases whose delinquency about the fee is a new symptom, brought forth by the therapeutic regression in the transference, it is the therapist's responsibility to conduct himself in such a way that the patient can become aware of his impulse (if possible without acting it out, of course). In the group of patients under consideration here, because of the primitive organization of the psychic apparatus, impulses *do* lead to acting out. To be sure, this can be prevented by not permitting regression to take place. The price for not having some difficulties in collecting one's fees is failure to deal with the core problems of these patients.

Several colleagues have questioned my thesis about the uniformity of the basic problem in these cases by citing examples in which they felt that anal or even phallic determinants were paramount (e.g. a woman withholding the

terminal payment for an analysis as a symbolic retention of the wished for paternal phallus). Whether these objections are valid would depend on closer examination of many more clinical instances. In my practice, however, the retained money was invariably a transitional object.

Finally, a word about practical application. Since I began to think about this problem within this theoretical framework, I have found

it possible (on one occasion at least) to 'disillusion' a patient 'gradually' enough to permit him to continue treatment and eventually to relinquish the transitional object by paying his bill in full. This has permitted the therapy to proceed to the exploration of crucial conflicts which could not be taken up until the establishment of increased trust through this experience.

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A COMMENT ON THE PSYCHODYNAMICS OF THE HYPNOTIC STATE

By

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Until recently, the principal psycho-analytical ideas of the hypnotic state were those put forward by Freud and Ferenczi, both of whom had had experience in using hypnotic techniques as a therapeutic procedure before turning to those of analysis. To recapitulate them very briefly: hypnosis was regarded as a masochistic identification with, and surrender to, a loved or feared person representing a projected parental imago for the hypnotized subject, the essence of the relationship being an unconscious erotic tie between subject and hypnotist on a regressed oedipal level.

In their 1952 paper, Brenman, Gill and Knight put forward the hypothesis '... that the hypnotic state involves not only the gratification of pregenital and oedipal needs but also a constantly changing balance between such needs, experiences of hostility, and defences against both these sets of instinctual impulses'. Here the authors mention the experiences of hostility of the hypnotized subject, and it is this aspect of the relationship that I wish to enlarge upon in this paper.

For some time before coming to psycho-analysis I had used hypnotherapy on patients, and for a period, I tried to amalgamate the two approaches. The patient would be hypnotized, and from the outset asked to free-associate while in the hypnotic trance. The associations would then be interpreted in terms of the transference-relationship between patient and hypnotist, and, almost invariably, I noticed that interpretations of hostility on the part of the patient towards the hypnotist would cause a considerable lightening of the trance state, and eventually that the patient could no longer be hypnotized. As this did not occur if libidinal impulses were interpreted, I concluded that the hypnotic state could exist only so long as aggressive impulses of the subject towards the

hypnotist were not made explicit. This sounds very obvious, but what are its implications for the dynamics of the hypnotic state itself?

Let us go back to the beginning. The original theory of hypnosis was based on the observable phenomena seen in the trance state. The subject goes into a trance at the suggestions of the hypnotist, and then produces various types of activity, motor, sensory, or ideational, in conformity with the latter's suggestions. In addition the subject feels and says that he is in the control of the hypnotist and has little volition of his own; in other words, that he feels that the hypnotist, and not himself, is the prime mover in the production of these phenomena. But as Ferenczi (1909) points out, the fact is that unless one believes in magic, the hypnotic phenomena are primarily the product of the subject's psyche, not of the hypnotist's. This raises an issue: if the subject is told that hypnosis results from his own magical beliefs in the supposed omnipotent qualities of the hypnotist, would he go into a hypnotic trance? The answer is supplied by the hypno-analyst, Wolberg (1945) in the chapter 'Hypnosis and the Transference', where he writes: 'During the early phases of hypno-analysis it is unwise to try to alter the patient's fantasies of the magic that he expects from the hypnotic process. To do so will cause him to respond with resistance and will block the emergence of other transference reactions. What he seems to want unconsciously from the relationship is to be able to depend upon a kind and omnipotent person. To inject interpretations at this stage may create panic or such contempt for the analyst as to interfere with achieving the proper trance depth and with the interpersonal relationship itself.'

Thus the hypnotic state is based on a deception—that the hypnotist must pretend to the patient that he is omnipotent, if he is to induce

a hypnotic trance. But what then is the meaning of this deception to the *unconscious* of the subject, which is 'aware' of the pretence? The answer suggested is that the subject feels that, with the hypnotist's collusion, he is omnipotently forcing the hypnotist to this deception, and is thereby in control of the hypnotic situation, i.e. that some omnipotent phantasy is being acted out. This argument is strengthened by the fact that a hypnotized subject cannot be made to produce phenomena that he resists. As in the fable, the 'frog'-hypnotist is being omnipotently converted by the subject into the 'puffed-up ox'. Thus, far from the trance relationship being only a passive masochistic identification and surrender on the part of the subject, the unconscious dynamic content is also an aggressive attack on the hypnotist, with the latter passively accepting, and glorying in, it. The hypnotic trance can be conceived of as a collusion between hypnotist and subject to deny this aggressive controlling attack on the hypnotist, and at the same time is an expression of this attack. This conception makes the hypnotic trance state comparable to that of an hysterical symptom, i.e. the impulse that is repressed (denied) and then returns in another form, but with the necessary condition here of the hypnotist's collusion, a state of affairs resembling *folie à deux*.

From this point of view, the phenomena of hypnosis can be looked at in a different way. If this is the underlying dynamic, two situations can arise. The first is of a heightened performance in the use of the subject's ability for reality testing, since anxieties about the hypnotist as a rival in this sphere can be dispensed with. The second situation is the opposite of this, i.e. the denial of the ability for reality testing, as, for example, in positive and negative hallucinations, analgesias, aphonia, etc., and this can be conceived of as an inner attack on the self which is under the sway of the reality-principle, and would result from fears of retaliation from the attacked hypnotist or of the unconscious guilt felt for the attack.

If would also offer some explanation of the recall and abreaction of memories, which was an important feature of the *Studies in Hysteria* period. Freud suggested (1921) that the hypnotist is put in place of the subject's ego-ideal (superego), but I would suggest that the superego is put in place of the hypnotist, and that this projected superego is controlled by the subject, with the collusion of the hypnotist. Thus the subject now feels free from the power of the

superego to a large extent, and can give fairly free rein to the emergence of previously repressed memories.

A further feature of this state is the compulsive nature of the response by the subject to the hypnotist's suggestions. If they are not complied with, anxiety is aroused in the subject, and this state of affairs is much akin to the anxiety aroused in the obsessional patient, who resists carrying out his obsessional activity. These activities are often regarded as being of a reparative nature, to undo the damage caused by unconscious aggression, and it is conceivable that the hypnotized subject's compliance is of the same order, to undo the damage caused to the hypnotist by his attack. Thus the guilt of the subject is a powerful factor in the reinforcing of the hypnotic state. This would help to explain observations made by Wolberg (1945), which arose when he did interpret the subject's hostility to the hypno-analyst, but at a much later stage of therapy. To quote him once more: 'The question may be asked whether an analysis of the hypnotic interpersonal relationship may not remove the very motivations that make hypnosis possible. In the vast majority of cases it has no such effect; usually a *peculiar dissociation* [my italics] exists. The patient continues to react to hypnosis, going into trance states while at the same time manifesting hostile feelings towards the analyst. Rarely does resistance developing out of analysis of the transference become so intense that the patient refuses to enter hypnosis.' I suggest that this 'peculiar dissociation' implies a split in the ego, and that it has occurred because the accumulation of guilt in the patient has reached such an intensity that hostility can only be expressed by means of such a split. Thus this split-off area cannot be explored in the course of a hypno-analysis, which means that a hypno-analysis is doomed from the start to be incomplete.

It is often found that when a subject emerges from the trance state, he uses certain types of phrases, such as 'I feel marvellous', 'Never felt better in my life', and the note of manic euphoria in these is unmistakable. I suggest that this manic state represents feelings of triumph following on the successful attack on the hypnotist. Further, the occasional headache, paraesthesia, etc., which may be complained of at this time will represent the converse of the manic state, i.e. a depressive state, resulting from the guilt for the attack. Thus the hypnotic state represents a collusive manic denial of a

controlling aggressive attack of the subject on the hypnotist, together with the denial of anxieties of retaliation and guilt associated with it. This would be a form of the manic defence, exhibiting, too, the three other characteristics of this defence, omnipotence, idealization, and ambivalence.

A patient emerging from the trance state, when asked to talk about his feelings in the

trance, said 'I thought you went deeper in hypnosis—that you were in control of the hypnotist'. This unconscious omission—he meant to say 'in *the* control of the hypnotist'—illustrates the thesis of this paper.

I would like to express my thanks to Dr J. L. Rowley for his constructive criticisms of this paper.

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BOOK REVIEWS

The Myth of Mental Illness. By Thomas S. Szasz, M.D. (New York: Hoeber, 1961; London: Secker & Warburg, 1962. Pp. 337. \$7.50. 35s.)

The difficulty with Szasz's book is to know how to take it. If one regards it as an essay in provocation, the intention of which is to disturb the complacency of the medical and psycho-analytical establishments by adopting a satirical stance towards their most cherished convictions and most basic assumptions, one must account *The Myth of Mental Illness* a success. Szasz, whose references reveal him as an admirer of Samuel Butler, has himself a lively sense of paradox, a talent for drawing unexpected analogies (e.g. between the contributions to human culture made by Chareot and Guillotin), and a refreshing freedom from inhibitions about making sweeping and unprovable generalizations (e.g. Freud's 'work was well recognized and eagerly accepted by contemporary scientists interested in the problems with which he dealt').

However, the indications are that Szasz wishes his book to be taken seriously, and that he believes himself to be putting forward a thesis of revolutionary importance to psychiatry, psychodynamics, and ethics. The present reviewer must however confess to a feeling that the central unifying theme has eluded him; as a result he is forced to restrict his comments to a number of particular propositions put forward by the author.

First, there is the myth of mental illness itself. Szasz's idea is that it is an illusion to suppose that persons suffering from psychogenic disorders are ill, and that this myth is held by physicians and patients for complementary and collusive reasons. It enables physicians to believe that everyone who suffers comes within their area of professional competence, an idea which enhances their social prestige, increases their power, and gives them opportunities for being patronizingly benevolent, while it enables 'patients' to evade the fact that their troubles arise from problems in living and failure to learn the rules of the game of life. In order to maintain this myth, sufferers have to pretend to be ill by developing symptoms which imitate those of physical illness, thereby sanctioning their atten-

dance upon the physician and his acceptance of them as patients.

Not unexpectedly, Szasz selects hysteria as the typical mental illness and argues that hysterical symptoms are pantomimic representations of physical symptoms, the purpose of which is to communicate non-verbally by means of iconic signs the statement 'I am suffering and need help'. It would appear that Szasz believes that only persons acquainted with the idea of epilepsy can produce hysterical seizures, and that the whole symptomatology of hysteria is the result of what old-fashioned steam analysts call secondary gain. I doubt whether either idea is true.

However, Szasz has much to say that is illuminating about the manipulative techniques of hysterics, the unwitting collusion of doctors with them, and the manifold ways in which the assertion of illness may be used evasively. It is indeed only when one discovers that he believes depression to be a pantomimic representation of the statement 'I am unhappy' that one begins to realize that he is simplifying matters grossly, and that he has no real appreciation of psychological reality and endopsychic conflict.

His chapter 'The Ethics of Helplessness and Helpfulness' affords an interesting example of this. Here he argues that the hysteric's wish to be regarded as ill (and the physician's wish to help him) is influenced by the Judaeo-Christian notion that there is virtue in being helpless, and he interprets much fear of happiness as deriving from fear of offending a jealous God. He concludes from this that Christianity is one of the causes of hysteria and that those who 'sincerely desire a scientifically respectable psychosocial theory of man . . . (will) have to pay far more attention to religious rules and values than has been our custom'. Here he completely misses the point that if God is a projection—as Szasz would, I think, maintain—the psychopathology of hysteria must centre round fear of offending an internal object who forbids happiness and self-assertion and that the manoeuvres of hysterics must stem from endopsychic conflict with this persecuting internal object. However, if Szasz had taken this step—which his occasional, usually parenthetic, en-

dorsements of internal object theory would entitle him to do—much of what he says about psychosocial theories of Man would have been revealed as trivialities.

Szasz's obliviousness of endopsychic reality is, I believe, responsible for his wish to eliminate the subjective notion of 'motive' (which he confuses with 'cause') from psychodynamic theory and to replace it by 'external' concepts such as role taking and games-playing. This lands him in the paradoxical position of fighting for the humanization of psychiatry by eliminating reductionist and causal notions only appropriate to the physical sciences, while he himself is dehumanizing it by eliminating such psychically real notions as guilt, anxiety, fantasy, and imagination, not one of which appears in his index. His whole discussion of the inappropriateness of naïve causal theories and physical models for psychodynamics would have been much improved by familiarity with Marjorie Brierley's ideas on process theory and personology and John Rickman's on psychoanalysis as an ahistorical science. But these regrettably appear not yet to have crossed the Atlantic, despite publication in the International Psycho-Analytical Library.

Lastly, we come to Szasz's idea that psychodynamics should be restated in terms of semiotics (the science of signs). Here Szasz comes very near to, but to my mind just misses, an idea which I have myself espoused, viz. that the next advance in psycho-analysis will be formulations in terms of communication-theory. Although I wholeheartedly endorsed Szasz's initial statement of this theme I found myself dissatisfied with his later elaborations. The initial statement runs:

'In fact, there is a split, perhaps even an unbridgeable gap, between what most psychotherapists and psychoanalysts do in the course of their work and what they say concerning the nature of it. What they do, of course, is to communicate with patients by means of language, nonverbal signs, and rules. Further, they analyze, by means of verbal symbols, the communicative interactions which they observe and in which they themselves engage. This, I believe, correctly describes the actual operations of psychoanalysis and psychosocially oriented psychiatry. But what do these psychiatrists tell themselves and others concerning their work? They talk as though they were physicians, physiologists, biologists, or even physicists!'

But even here I find myself in disagreement with the last sentence I have quoted. It seems to me that he has made things too easy for himself and has let an impressive number of babies out with the bath water by attempting to formulate a communication theory divorced from physiology and biology. Not only is there the fact that some of the primary processes (e.g. condensation and over-determination) bear a remarkable resemblance to the processes (e.g. summation, facilitation, final common pathway) of neuro-physiological integration, but there is also the psycho-analytical evidence that the starting-point of all symbol formation is perception of one's own bodily parts and processes. In his sub-section entitled 'The Concept of Symbol in Psychoanalysis' Szasz shows no evidence of ever having read Jones's classic 1916 paper or indeed any later papers on the subject, and he assumes that the analytical theory of symbolism amounts to no more than asserting that objects which resemble something may symbolize it, and ignores completely that it is a theory about the genesis of symbolic thinking from the matrix of biological processes. As a result his own theory of symbolic communication, despite its ability to deal with the pathology of the established capacity to think and communicate—Szasz is masterly on the psychology of hinting, innuendo, lying, etc.—would seem unfitted to deal with disturbances of the symbolic function itself, and one is at a loss to see how, for instance, delusional thinking or psychosomatic disturbances could be illuminated by it; and yet both these are undoubtedly disorders of communication and are also conditions with which psychiatrists have to concern themselves both in theory and practice, notwithstanding any convictions they may have that 'Mental Illness is a Myth'.

Charles Rycroft

Schizophrenia as a Human Process. By Harry Stack Sullivan. With Introduction and Commentaries by Helen Swick Perry. (New York: Norton, 1962. Pp. 363. \$6.50.)

This book presents all the major articles on schizophrenia by H. S. Sullivan from the beginning of his writing career (1924), when he was 32, until 1935. Each article is prefaced by a short commentary by the editor, Helen Swick Perry, who also contributes a valuable introduction. This includes a more detailed description of

Sullivan's set-up at the Sheppard-Pratt Hospital than has hitherto been published. A short appreciation of Sullivan 'the man' is included, by Clara Thompson, with whom he had undergone formal analytic training beginning in 1930.

The book is interesting partly for historical reasons, for not all is the definitive Sullivan in his maturity. It reveals very well his struggle to find his own voice. When he does, what a biting, bracing verve he has. When he does not hit it off, the less said the better. Sullivan's style, in any event, never lacks *presence*.

At the start, he is already beginning to part company with the Kraepelinian-Bleulerian clinical-constitutional-genetic axis. While giving Bleuler credit for breaking new ground in psychiatry, he appraised his work on schizophrenia, correctly in my view, as 'unsatisfactory alike in its basis in the old idea-association psychology and in its contradictory, if not actually incoherent, propositions' (p. 13). (How Bleuler's study of schizophrenia, as confused as it is painstaking, has come to be rated so highly by some usually discriminating critics, Zilboorg for example, is a mystery to me.) Almost as quickly he dissociated himself from the Freud-Abraham view that 'dementia praecox' represented an inability to transfer, a withdrawal of interest from the external world, and a concomitant inflation of the ego, and so on. By the time he was 40, he had clearly found his own stance.

Sullivan's views on schizophrenia are too well known to require detailed re-exposition at this late date. I shall limit myself to comments on three aspects of his work.

First, the nature of his data. Sullivan was one of the very first to tape-record his interviews with patients, and he must have been among the first also to present extended transcripts of such recordings as evidence for his conclusions. In this respect he was well in advance of his time and, unfortunately, still in advance of much of the present. So many reports of so-called mechanisms 'found in schizophrenia' supposed to characterize schizophrenics in particular, are not descriptions of what goes on 'in' the patient, but descriptions of events in the psychiatrist's or analyst's mind which are the ghostly double of what he thinks is going on somewhere 'in' the other person. The 'scientific' paper in which is reported what Freud or Federn had to say about narcissistic neurosis or

ego boundaries, then what Peter or Paul had to say, followed by what the author has to say, in agreement or disagreement, with or without emendations, supported by that extraordinary postdictive horoscope known as a 'clinical' history, and a few sentences more or less imperfectly remembered, purporting to have been uttered by this or that patient in God knows what context, but clearly confirming the author's theory, tells us little except what that particular writer is selectively aware of, and to those of his readers who are selectively attentive to other aspects, it reveals of course plainly enough to *them* what he selectively does *not* notice. All this is now a waste of time in the field of schizophrenia.

Sullivan was genuinely concerned with schizophrenic phenomenology, and he found he could not pluck this out of its interpersonal context. If he was at times wrong, we have his relatively unselected data from which to draw our own conclusions. He presents real persons, not illustrative specimens of disordered thought, or what not.

Therapeutically, Sullivan's work at the Sheppard-Pratt Hospital showed clearly that very rarely need a person remain mad for more than a few months, given an ordinary good enough environment, to borrow Winnicott's expression. This requires a small homogeneous unit, nurses or social therapists selected on the basis of their ability to interact non-destructively with schizophrenics, the elimination of what Goffman¹ has recently called the degradation ceremonials and subsequent profanations and humiliations of and to self, that the person is subject to at the inception of his career as a mental hospital patient, and subsequently. He was also aware that given a high institutional recovery rate, the relapse rate would be correspondingly high, 'for our improving patients will be hurried out into bad situations before they have consolidated enough insight, enough personality reorganization, to survive the morbid personal environments to which they must return. When, however, the efficiency of socio-psychiatric treatment has been demonstrated, I surmise that we will be encouraged to develop convalescent camps and communities for those on their way to mental health' (p. 269).

For Sullivan the schizophrenic is caught in various stresses and contradictions in his personal life imposed by the confused culture of

¹ Goffman, E. (1961). *Asylums*. (New York: Anchor Books. London: W. H. Allen.)

Western industrial society, mediated primarily by his relatives, focused particularly on sex. These contradictions he attempts to resolve or circumvent by manoeuvres, quite understandable in the circumstances, but capable of leading him unwittingly into a new and worse set of contradictions. Forbidden sexual satisfactions, he seeks solace in homosexual intimacy. Threatened or exploited therein, he attempts a sexless life, or pretends to himself or others that he is a Don Juan, while developing a secret life of masturbation in which usually non-socialized body functions, e.g. bowel tensions, take on meaning in imaginary and later in actual interpersonal situations, and so on.

Why, of course, is everyone not schizophrenic? Are the stresses to which the schizophrenic is subject peculiarly schizogenic: or do many people, placed in similar contexts, not become schizophrenic? More cogently still, do any people *not* placed in specific highly stressful interpersonal contexts ever become schizophrenic?

The schizogenic stresses Sullivan describes are not sufficiently specific. In his time he had not the theoretical or methodological means of going further. Only in the last decade have theory and method so developed that research has begun to answer the key questions raised explicitly by Sullivan's view of schizophrenia.

Sullivan saw the problem clearly enough.

'The peculiar characteristics of the parents of schizophrenic youths are represented by such precipitates of psychiatric experience as is the statement, "You can never secure a history from the mother of a schizophrenic". The only question that can be raised by fair-minded critics is one as to the universality of the influences which some of us allege to be determining in the occurrence of schizophrenia. It has been the misfortune of so-called dynamic psychology or psychopathology that it has proceeded over the enormous field of factual material with a large measure of disregard for inferential control by statistical and similar methods' (p. 188).

But what Sullivan also saw was that the unit of study cannot be the person who is the object of that confused set of attributions loosely dignified as the condition, state, or syndrome, 'schizophrenia'.

The locus of the relevant events is not 'in' the individual, but 'is in a nexus of persons and their relations' (p. 261), and necessarily, 'not sick individuals, but complex peculiarly charac-

terized situations' are to be 'the subject-matter of research and therapy' (p. 261).

Reading these articles by Sullivan written thirty to forty years ago is a somewhat depressing experience. They are altogether more contemporary than they should be. What were brave sometimes reckless dicta then, should have become hypotheses, long since confirmed or disconfirmed. Instead, most of the issues are still open, most of the work that Sullivan's vision demanded is still not done. Perhaps there is still time.

R. D. Laing

The Training of Psychotherapists—A Multidisciplinary Approach. Edited by Nicholas P. Dellis and Herbert K. Stone. (Baton Rouge: Louisiana State Univ. Press, 1961. Pp. 195. \$5.00.)

This book is a record of a symposium organized to bring together representatives of the various professional groups (psychiatrists, clinical psychologists, social caseworkers) involved in the training of psychotherapists. The meetings were held over a three-day period at the Southeast Louisiana Hospital in February 1959.

Different schools of thought had free expression by experts, and the discussions revealed important problems, many of them impossible of solution at the present time but at least recognized for future investigation.

A recognition of the part played in the development of the human mind by unconscious mental processes which has followed Freud's original work with the technique of psycho-analysis has infiltrated many allied disciplines, such as epidemiology, child guidance, and all forms of psychotherapeutic treatment. The result is that psychotherapists are needed for preventive therapy in epidemiology, for all forms of child guidance, including child analysis, for group work in order to ameliorate neurotic reactions, and also for intensive psycho-analytical treatment and research into psychotic states.

The epilogue to this book states in a clear and perhaps over-simplified form the main problems with which all psychotherapists are faced:

1. What is psychotherapy.
2. Who should undertake psychotherapy.
3. Training of psychotherapists, including psycho-analysts.

I think it is best to take these three problems separately, although they tend to have much in common.

The discussion on the definition of psychotherapy throws considerable light on the basic character of the real subject of the symposium as a whole. This concerns the present position of the treatment of mental illness by psychical methods, and how modern methods are linked with the development of social methods of recognizing and attempting to meet the needs of human beings regardless of secondary gains. This is so because the world is attempting to make the group rather than the individual the unit of power; hence the importance of epidemiology, which can organize living conditions therapeutically and thus prevent or minimize environmental contributions to mental illness. It is obvious that the more those responsible for carrying out the therapeutic measures know of the nature of mental illness the better, but it is impossible for them to have specialized knowledge of unconscious processes just as it is impossible for the surgeon to know all about the varieties of blood diseases.

The discussion on the definition of psychotherapy threw up many differences of opinion, which were partly dependent on differences in the training and experience of the discussants. The partial acceptance of the existence and influence of unconscious processes in the development of the mind by members of therapeutic groups who have not themselves experienced psycho-analysis is bound to make it impossible to generalize on the subject of training for psychotherapy. This difficulty, in my opinion, is due not only to the fact that some of those taking part had not had the personal experience of a training in psycho-analytical technique, but also to the present-day application of psycho-analytical interpretive methods to relieve immediate present-day tensions, as in group work, short-term psychotherapy, and epidemiological preventive advice by psychologists and social workers. There is no doubt that the therapeutic significance of work of this kind is valuable, and that it can be applied to a much larger proportion of the public than can be treated by psycho-analysis, but it must be recognized that it is largely concerned with an environmental immediate emotional situation which often can be modified or tolerated by increased conscious understanding, and not with a technique which induces intra-psychic structural changes. It is obvious that there have been in the past individuals gifted with insight into mental illness who have not learnt that insight from others, or have not studied psychology,

psychiatry, or sociology, but the therapeutic influence of such people seems to have depended on an ability to communicate with and not be afraid of mental conflict, and not to have included a grasp of the essential dynamics. It is Freud's contribution to the understanding of mental processes which has given psychotherapy the rank of a science.

In the summing-up in the epilogue it was agreed almost unanimously by the participants that in a majority of emotional disorders psycho-analysis was no longer considered to be the treatment of choice. Dr Harold Lief held the view that psychotherapy was generic, that psycho-analysis was one particular form of psychotherapy, and that the goal of training was to produce psychotherapists who could undertake all types of psychotherapy with all kinds of patients in all kinds of situations.

A generalization of this kind includes the recognition that a drive to help other human beings with emotional problems has existed in mankind probably at all times, and certain persons seem to be born with the ability to offer this help and to have intuitive understanding which can be called a power of healing. What is absent from this generalization is the fact that the psychotherapy of today has gained knowledge of a scientific character as a result of psycho-analytical research. The advance in knowledge of mental processes as a result of psycho-analysis is now partly incorporated in the general knowledge of the causes of emotional problems, and therefore its relationship to psycho-analysis is overlooked. This is, of course, comparable to what happens when there are advances in our knowledge of other physical or mental states. What at first was regarded as a discovery is now taken as common knowledge.

Psycho-analytical work on ego development is still in its early stages. We are not yet always clear about ego differentiation continuing along the same patterns which first occurred in childhood. The latest work on faulty thinking in adults, for example, demonstrates the pattern which first arose in connexion with early phantasy life. When it is said that psychotherapy can deal with present-day emotional problems, it may be by suggestive transference, but treatment is much more permanently effective if the ego patterns are understood and the dynamic of transference is interpreted. This is not likely to be recognized unless the therapist has himself been analysed, the point being that that technique is a necessary specialization. While

specialization has disadvantages and can be over-developed, it is obvious in the region of mental processes that not nearly enough direct research by psycho-analytical methods has been carried out and recorded. If psycho-analytical research is limited because of the need for quick therapy, further advances are not likely to take place, except perhaps in starting sociological preventive work, particularly in the upbringing of children.

The question who should do psychotherapy is relevant not only because of the problem already mentioned concerning the necessity for a psycho-analytical training, but because of the wide field open to therapeutic influences. Non-medical analysts have been accepted in England and have shown the value of knowledge of disciplines other than medicine in the training of psycho-analysts.

At the present time, when child guidance work and social work is important, it is obvious that the situation calls for so many therapists that non-medically-qualified people must be accepted, and training in classical analysis cannot be provided for them all, so that a modified curriculum is necessary. A knowledge of sociology and education is valuable. As Dr Boehm points out (p. 180), the task of the psychoanalyst is to bring about changes in the psychic structure of the patient, whilst the psychotherapist does not necessarily attempt this, but aims at increasing the patient's tolerance or supporting environmental changes.

Experience shows that trained psycho-analysts can undertake superficial psychotherapy if the situation calls for it, as they do in the outpatient departments of hospitals under the Health Service, but the handling of the transference, which is the most important factor in producing therapeutic changes, cannot be carried on successfully without continuity of contact between doctor and patient. The relationship between patient and doctor in short and interrupted psychotherapy is of the character occurring in hypnotic treatment, and the patient responds to suggestion.

With the acceptance of the fact that psycho-analytical knowledge is spreading into various methods of psychotherapeutic treatment, and into epidemiology, where it contributes to preventive measures by educational and social reforms, it is obvious that the question of methods and organization of training is a complex one.

In England at the present time the British

Psycho-Analytical Society and the Institute of Psycho-Analysis offer training for a qualification to practise psycho-analysis on adult patients and opportunities for additional training in child analysis. A number of the Associate Members and Members of the Society practise psychotherapy on psycho-analytical lines at many of the National Health Service hospitals, and in private practice use classical technique. The selection of candidates and the organization of training were discussed in the symposium.

In the present state of our knowledge we are not in a position to classify individuals into those who will make good analysts and those who will not. A certain proportion of trained psychoanalysts can be regarded as good technicians and can be trusted to achieve good therapeutic results with a certain number of patients.

It is sound to regard classical psycho-analysis as essentially research work, and the therapist should have attained a basic psychological independence which will enable him to increase his understanding of his patients and see the solution of psychical problems which he has not necessarily been taught to look for.

While it is expedient in many instances to select for training candidates who have a full unprofessional life, yet it must be recognized that it is not always the most normally developed psyche which is capable of creative thinking, and important insight can be present when the ego development is complicated. Provided the personal training analysis is successful and a balanced adaptation is obtained, the candidate may be of value as a research worker. It seems desirable that special efforts should be made at the present time to organize research on the selection of candidates by keeping records of the preliminary interviews and subsequent progress of the accepted student, and studying the results. It should be possible to recognize what type of student is more likely to succeed in child work or group work than in adult classical research.

I think the impression left by this book is that the unsolved problems connected with the development and organization of psycho-therapy and of psycho-analysis, particularly in respect of training, are crying out for attention and research.

Sylvia Payne

Painting and the Inner World. By Adrian Stokes. Including a dialogue with Donald Meltzer. (London: Tavistock, 1963. Pp. 85. 18s.)

Adrian Stokes's latest book presents us with the same task that his previous ones did: he

not only writes as a painter, he writes like a painter, that is to say like a painter paints. Thick blobs of word and thought have to be viewed and assimilated in fast procession; concepts and ideas take visual shape before our eyes. The depth and intensity of the writer's inner experience demand, however, slow translation into thought, in order to get the full impact of the author's intentions. One often wishes to exclaim, 'Make us a picture book of what you think—language is too slow, it has its inherent laws of time. What you demand of us underlies the experience of seeing pictures and not of reading words!'

Painting and the Inner World consists of three sections; each one could stand by itself. 'Chaos' and 'stabilization' are the author's expressions for what Freudians would approximately subsume first under the widest concept of the dynamic pleasure-pain principle. Of course, Stokes is justified in using two more passionate words instead of Freud's reasoned and sober ones, since he speaks of the artist who in every generation represents the most luscious flower which its culture has produced.

When Stokes joins his ideas with our cumbersome psycho-analytic concepts, that is the moment which requires from both of us some hard and critical thinking. That one paints one's inner world is almost common knowledge. Freud described this inner world more as a museum than a dramatic stage which shifts continuously; the latter being an idea which Klein has developed to the great benefit of psycho-analysis. These shifts are worth our constant attention, and the reviewer's recommendation would be that Part I of Stokes's book is a good introduction to this inner stage. Part II, a public dialogue between Stokes and Meltzer, a psycho-analyst of the Kleinian school, is for that reason also the most important one. Meltzer makes a good job of putting before us once more the basic ideas of Klein which led her to make a deep inroad into the application of her findings to artistic processes. Conceptualization is not yet to be found in her modern and subtle way of describing mental function. Her way of viewing the child and his play is more or less to give a running commentary on mental life. We think here of Nietzsche's words, 'In every man there is a hidden a child who wants to play.'

It did not become quite clear to me why Stokes thinks of an artist's subjection to his time as a slavery, 'since art must reflect typical experience inherent in the milieu in which he

lives'. The author seems to stress this slavery, and says that it is entirely ignored by psychoanalysts. Had he based his arguments on the Freudian concepts of phase and development (in cultures as well as in individuals) he would, perhaps, not have felt as he does. Meltzer stresses in a few words the important difference between Freud and Klein, in that the latter does not use the concept of phase and development, but rather that of position, where the emphasis lies with the organization of the self and can best be understood in terms of changing object relations. Clearly here lies the key point of an essential divergence in psycho-analytic thinking. To Klein the early ego is different from the adult one merely in that more important things happen to the young ego; not because of the vast differences in the possibilities of what can and does happen owing to processes of maturation. Klein thinks in terms of following up subtleties in object-relationships, but how can we dare to approach these subtleties except in a framework which is subject to some intrinsic and determinable law? Otherwise we dream with the dreamer. But the artist does not dream: he acts, he proceeds to create, and he creates as an adult, not as a child does. Freud's ideas do not stop where the artist rejects reality; he thinks of the artist as the fulfiller of a great cultural task by leading us straight into the realm of the unconscious. Although there is no dearth of Stokes's penetrating ideas on art, he would not have called the Freudian concept of the task of artistic endeavour as giving us 'the sugar-coated pill', had he made himself familiar with Freud's deep reverence for the creative process in artists. Thus, tolerance is a virtue hardly practised by artists and thinkers. Perhaps it needs the humble harvester of their productions to be able to exercise this tolerance.

Part III of Stokes's book is a monograph on the English landscape painter, Turner (1775–1851), on how his art became gradually the complete expression of the artist himself. This is a beautiful account of a painter's inner world, and at the same time, almost imperceptibly, it is an account of the turn from the eighteenth to the nineteenth century, a phase which was so prolific in creating great artists, musicians, and writers in middle Europe.

The absence of all reproductions is a very telling confession contained in the book: the words on every page are themselves illustrations and pictures and need to be looked at for quite

some time before they fully reveal their meaning to the reader.

Eva M. Rosenfeld

Thalassa: Psychanalyse des origines de la vie sexuelle. By Sandor Ferenczi. (Paris: Petite Bibliothèque Payot, No. 28, 1962. Pp. 186.)

This long overdue first French edition of Ferenczi's *Thalassa* (1924) deserves the sincerest compliments on the part of the psycho-analytic movement. This imaginative and brilliant work was, in its time, a milestone in the history of psycho-analytical theory. The presentation, by the devoted labours of its editor, M. N. Abraham, is exemplary in its kind. Both the erudite translations (by MM. J. Dupont and S. Samama, and Mlle Grin), obviously supervised by the Hungarian-born editor, are up to the mark, tidy and clear. The editing itself is as scholarly and precise as to set an example. The pleasing paper-back edition comprises a comparison of the different texts and their modifications, a short chronological table (both biographical and bibliographical), a dexterously abbreviated yet explicit and clear-cut index which contains also the concise definitions of the neologisms used by Ferenczi, and, above all, an excellent preface by the editor. M. N. Abraham stresses the historical and theoretical importance of Ferenczi's work, emphasizing his 'orthodox view' in which he was 'more Freudian than the master himself': that the repetition compulsion stemmed not, as Freud later would have it, from the death instinct, but from the life instinct, i.e. from the libidinal need to repeat pleasurable experiences. The editor also points out that Ferenczi was the first to search for the biological foundations of the 'mysterious leap' in hysterical conversion from the mind into the soma, thus extending psycho-analytical theory into the domain of biology and laying the foundation of a theory of symbolism, inseparably linked with the postulates of the pleasure principle. This, according to him, is based on the paradigm of the body's ability to be used for symbolizing the unconscious, by creating an archaic, pre-verbal language. Whatever our present views on this subject may be, we are bound to accept the pioneer value of Ferenczi's work and appreciate the merits of M. N. Abraham's painstaking endeavour to rekindle our interest in Ferenczi's ideas and bring them nearer to our present-day thinking.

L. Veszy-Wagner

Contemporary European Psychiatry. Edited by Leopold Bellak. (New York: Grove Press, 1962. Pp. 372. \$7.50.)

American and European psychiatry are much more closely related and interdependent than superficial comparison suggests. American psychiatry is highly sophisticated methodologically, but apart from its emphasis on the psychodynamic and the sociological approach it has not yet evolved new concepts. European psychiatry has neglected methodology but has until recently been rich in original and fertile ideas. A marriage of the two could, in the editor's opinion, bring about a 'happy combination of adaptive originality and rigid control; of creativity and methodological sophistication'. The bane of European psychiatry is the lack of facilities for research, while American psychiatry suffers from excessive preoccupation with methodology and over-dependence on grant-giving committees. The editor invited leading representatives from France, Germany and Austria, Great Britain, Italy, Scandinavia, the Soviet Union, and Switzerland to write about the trends in psychiatry in their respective countries. Inevitably, the contributions are uneven and uncritical in parts. However, they successfully convey the orientation of psychiatry in the different countries. The method of presentation tends to exaggerate the differences between the various approaches. The intelligent reader will find this Cook's tour through European psychiatry conducted by native guides highly educative and thought-provoking.

E. Stengel

The Origins of Science: An Enquiry into the Foundations of Western Thought. By Ernest H. Hutten. (London: Allen & Unwin, 1962. Pp. 241. 28s.)

During the five years of this book's making, I was privileged to hear some sections of it presented to the Imago group (London). Stimulating as it was in bits, it becomes impressive and valuable as an integrated work which contributes a long-needed implementation of psycho-analytic insight into mental functioning with specific reference to man's (currently) most impressive activity, science.

Dr Hutten, whose beginnings in the physical and mathematical sciences carried him later into philosophy, has acquired an impressive understanding of psycho-analytic theory and

technique which he marshals throughout this book to build up the truly modern conception of science as a human activity in which discovery and invention must be wedded in order to bring about an integrated functioning of observation, abstraction, systematization, and validation—all carried on under the tension of infantile anxieties. He discriminates clearly between truly scientific and pseudo-scientific activity, showing us how integration with the past expresses itself in true science, in the sense of Bohr's 'Correspondence Principle', building new theories which embrace and enlarge rather than destroy the old ones.

It is in the light of this respect for the past, untainted by infantile awe, that Dr Hutten is able, in the earlier chapters, to show us with astonishing clarity (astonishing at least to anyone whose knowledge of ancient history and philosophy is less than professional) how the ideas of object and of causality have evolved from the various Hellenic schools, to the Renaissance conceptions, still static though now experimental, and on to the present dynamic view of inner and outer reality. By means of this historical approach, he is able to trace for us the evolution of epistemology, via mathematics and logic, to its current position which embraces in an integrated way coherence, correspondence, pragmatic and semantic theories of truth.

While this book is of special interest to psycho-analysts because of its vigorous use of analytic theory for scrutinizing the history of science, its claim to value as a contribution to

the psycho-analytic literature is not at first glance obvious. To my mind this value is rather hidden in Part IV, 'Science as a Creative Activity'. In one small sentence Dr Hutten has linked the modern developments in psycho-analysis to the best of the new developments in philosophy, especially Russell's hierarchy of languages and the entire new emphasis on *levels* as against *patterns*. 'Instead of releasing tension immediately as the child does, the scientist makes use of it in order to overcome the barrier of anxiety that separates one level of abstraction from the next higher one' (p. 208).

In this sentence, and its further elaboration by Dr Hutten, we find a highly knowledgeable appreciation of the work of Freud, as inventor (of the method of psycho-analytic investigation) and discoverer (of the layered structure of the mental apparatus). I find this the most convincing argument for the justice of Freud's appropriation of the term *meta-psychology*.

Books of this sort, eschewing metaphysics and bringing together a wide knowledge of various sciences, are bound to enhance the reawakening respect for philosophy as the meta-language to which all scientists must look to be taught to converse with one another across the barriers of specialization. It is because of its unusual value that the book's defects of format are so irritating: its poverty of references and inadequate bibliography. I think Dr Hutten has perhaps underestimated the seminal function of his book—a manifestation of infantile denial, to turn his own method of argument against him.

Donald Meltzer

122nd BULLETIN OF THE INTERNATIONAL PSYCHO-ANALYTICAL ASSOCIATION

Edited by
ELIZABETH R. ZETZEL, *Hon. Secretary*

The following letter has been received as a comment on the 'Communication from the President about the Neoanalytic Movement' which appeared in the 120th *Bulletin* of the Association. It is published with the concurrence of the officers and members of the Central Executive.

Dr Gitelson has advised the Editor of the *Bulletin* that there was one error of fact in his Communication: the Academy of Psychoanalysis is an American society, but it is not officially named 'American Academy of Psychoanalysis' (p. 374, first column). As to the question of sponsorship of the International Forum for Psychoanalysis, Dr Gitelson wishes to call to the attention of the membership the following note from the *Newsletter* of the American Psychiatric Association, 14, 5 January, 1962:

'*Internatl. Psch. Forum*, Amsterdam, Holland, July 27-31, '62, under auspices of Acad. of Psch. and several European Psch. groups. (Write Leon Salzman, 1610 N. Hampshire Ave., Wash., D.C.).'

Dr Salzman was a Trustee of the Academy for the term 1960-63.

NEO-ANALYSIS OR NEO-ATAVISM

Dr Elizabeth Zetzel, Hon. Secretary and Editor of the *Bulletin*,
International Psycho-Analytical Association,
63 New Cavendish Street,
London, W.1, England.

To the Editor:

Dr M. Gitelson's recent 'Communication from the President about the Neoanalytical Movement' (*Int. J. Psychoanal.*, 43, 4-5, 1962) seems to require some correction in order to restore the balance of probity and professional

dignity of your respected *Bulletin*. This reply is therefore addressed to your readers rather than to Dr Gitelson, who in past correspondence¹ has proved to be a nebulous and eventually uninteresting protagonist inclined to evade issues by orotund sentences like this one, except that his nouns generally have no consistent meanings, and are followed six lines later by predicates that connote no tangible processes. However, in the particular 'Communication' referred to, Dr Gitelson made his allegations slightly more explicit than usual, and it is with reference to these that your readers may appreciate the following facts:

First, there is no 'American Academy of Psychoanalysis'. The Academy of Psychoanalysis, founded in 1956 by some of the leading psychoanalysts in the United States—nearly all of them members of the International Psychoanalytic Association—has in six years grown so greatly in scientific prestige and influence that:

(a) Its Fellowship now includes some of the world's most renowned senior psychoanalysts: e.g. Franz Alexander, Carl Binger, Dexter Bullard, Roy Grinker, Martin Grotjahn, Abraham Kardiner, Judd Marmor, John Millet, George Mohr, Sandor Rado, Janet Rioch, May Romm, William Silverberg, Edith Weigert *et al.* Five of these have been Presidents of the Academy, which now numbers over 400 prominent analysts on both American continents.

(b) Dr Gitelson correctly notes that many of these Fellows of the Academy are also dues-paying members of the American Psychoanalytic Association, and thereby the International; indeed, the number is increasing monthly. However, it is not true, as Dr Gitelson avers, that they 'have no sympathy

¹ Cf. my previous exchange of letters with Dr Gitelson in 'Transference: Counter and Countered—a Dialogue', pp. 160-172, of Salzman, L. and Masserman, J. H. (Eds.):

Modern Concepts of Psychoanalysis, N.Y., Philosophical Library, 1962.

for the American Psychoanalytic Association'; on the contrary, they are deeply sympathetic with the current travails of the American Psychoanalytic, and therefore retain their membership and influence in that Association in the hope that, to use Freud's phrase, 'the soft voice of the intellect' will eventually prevail in its doctrinaire, administrative and pedagogic councils.

(c) Dr Gitelson also inveighs against the Academy's designation of non-voting Scientific Associates—a widely sought elective honor which has been reserved for about fourscore of America's leading anthropologists, sociologists, psychiatrists and other behavioral scientists, including about half of the Chairmen of the Department of Psychiatry in United States universities, each of whom had rendered outstanding contributions to psychiatry and psychoanalysis. In this connection, it appears incredible that Dr Gitelson is serious in his implied strictures that analysts should be unique among scientists in not being interested in, and avidly receptive of, developments in other fields that could advance understanding and skill in their own science. Let us trust that our potential friends in these related disciplines will not take his attitude as representative.

Second, Dr Gitelson's allegation that the Academy is 'politically active' is, to use two of his favourite panchrestons,² more 'tendentious' than 'diatrophic' (unless Dr Gitelson reads the latter term as *di-atrophic*). The Constitution of the Academy specifically confines its purposes to research and communication and to the promotion of psychoanalysis as a scientific discipline; indeed, it expressly forbids not only the establishment, but the 'approval' or 'disapproval' of Institutes, Societies, Standards of Training or other pre-emptive or quasi-official regulative activities. The only approach to 'political' action in which the Academy was ever even distantly involved occurred in 1959 when the American Board of Psychiatry and Neurology, considering the Academy an authoritative and impartial body, sought its advice as to whether or not to establish a Subspecialty Board of Examiners in Psychoanalysis and invited the Academy to nominate such examiners if the Board were established. The Academy, after serious deliberation, counselled against the

establishment of such a Board, and the wisdom of this advice was later confirmed when the American Psychoanalytic Association reversed its previous stand and echoed the Academy's recommendation.

Third, Dr Gitelson's somewhat free-wheeling accusation that the activities of the Academy constitute 'active opposition to psychoanalysis which leaves no doubt about the wish to negate its discoveries' must have led to many a doubt as to Dr Gitelson's accuracy of reporting and impartiality of judgment on the part of readers acquainted with the following facts:

1. The biannual scientific meetings of the Academy are invariably attended not only by its Fellows and Scientific Associates, but by many other members of the American Psychoanalytic and guests from various scientific societies who desire to learn of fundamental progress in this field.

2. The Academy has been designated as a constituent body of the American Association for the Advancement of Science, and the two associations, under the Chairmanship of Dr Sandor Rado, held an historic Joint Meeting on Aggression and Warfare on December 26–28, 1962.

3. The Scientific Proceedings of the Academy, published by Grune and Stratton under the title *Science and Psychoanalysis*, has attained world-wide circulation and acclaim and is being translated into several languages.

4. Basic Book Publishers, contemplating a definitive summation of psychoanalytic knowledge to date, delegated the planning and writing of this organon to the Academy as the most competent and respected scientific organization in the field, and selected Dr Roy Grinker, Sr., then President of the Academy, as Editor.

Fourth—and this time a minor but perennially necessary correction of Dr Gitelson's writings—the Academy had and has no official connection whatever with the International Psychoanalytic Forum.

Finally, Dr Gitelson's dictum that we must 'be uncompromising in the application of our psycho-analytic insight into our authoritarian [sic!] roles as teachers and educators' is so scholastically anachronistic—and so contrary to the asymptotic but free and productive seeking

² Garrett Hardin's term for words so protean in their connotations that they are essentially meaningless.

for truth upon which both science and ethics are based—that it would be charitable to regard it as a *lapsus* rather than a *credo*. However, this leads me to a more general comment about the necessity of recognizing dictatorial reactionary movements in all branches of human endeavor. Perhaps a trenchant analogy in current history would here be apropos:

The Catholic Church, too, has its Alfredo Cardinal Ottaviani, Secretary of the Supreme Sacred Congregation of the Holy Office, whose coat-of-arms proudly bears the motto *Semper idem* and whose creed is 'Scripture must be read under ecclesiastical guidance'. At the recent Ecumenical Council, progressive elements of the Church, led by Augustine Cardinal Bea, Head of the Secretariat for Promoting Christian Unity, deplored Ottaviani's doctrinal intransigence because it 'would close the door to intellectual

Europe and the outstretched hands of friendship in the old and new world'. The Council, cognizant of broader vistas of scholarship and new obligations to humanity, rejected Ottaviani's narrow concepts of 'orthodoxy' and followed a greater destiny. Shall scientific societies seeking deeper knowledge of, and greater service to mankind in other fields, do less?

From past experience, I can presume that Dr Gitelson will want to respond; from the same experience, it would be wise to express the hope that in his future discussions he will be less arbitrary or jejune *ad hominem*, and more factual and responsible, since most of us are interested only in discourses that can be so characterized.

Respectfully,
(Signed) JULES H. MASSERMAN, M.D.

CLINICAL ESSAY PRIZE

Members and Associate Members of the International Psycho-Analytical Association are reminded that competitors for the Clinical Essay Prize must send in their work to the Hon. Scientific Secretary of the Institute of Psycho-Analysis, 63 New Cavendish Street, London, W.1, by 31 March of the year in which they wish to enter the competition.

The conditions governing the competition are the following:

A prize of £20 is offered.

Requirements for the Essay

The essay shall consist of a clinical record of a case treated by psycho-analysis. It should illustrate clearly the events and changes in the mental life of the patient and their relation to external environment. In awarding the prize, the Judges will pay attention to acuity of observation and the clarity with which the facts are stated. If the writer wishes to draw theoretical conclusions, he must bear in mind the necessity of making the evidence for such conclusions carry conviction.

It is recommended that the length of the essay should not exceed 20,000 words.

The Essay shall not have been published in any book, journal, or other form of publication and shall not have been read to or have formed the subject of discussion at any formally constituted meeting of psycho-analysts.

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Essays must be submitted on or before 31 March in any year. They must be in the English language, in typescript on quarto paper with ample left-hand margin. They must be in triplicate and be sent to the Hon. Scientific Secretary of the Institute. All copies of essays submitted become *ipso facto* the property of the Institute (or its successor) while it has the appointment of the Trustees for the Prize Fund.

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ELLIOTT JAKES,

*Honorary Scientific Secretary,
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Part 4

THE REPETITION COMPULSION AND 'MATURATIONAL' DRIVE-REPRESENTATIVES

By

THEODORE LIPIN, NEW YORK

In this reinvestigation of the repetition compulsion, one type of repetitive phenomenon prominent in analysands with certain psychopathology is examined for its empirical features. The findings are then used to infer the characteristics of certain instinctual drive representatives, their underlying drive processes and their contributions to normal and abnormal functioning. The scope of this study does not include consideration of Freud's almost cosmological hypotheses, on a high level of abstraction, about the characteristics of instincts as entities and about the theory of life and death instincts.

I. *Freud's Discovery*

Building on thirty years of pioneering work in the field of mental phenomena, Freud reported in 'The Uncanny' (1919) and *Beyond the Pleasure Principle* (1920) his discovery of a newly discerned empirical entity.

From all the varieties of observable recurrent phenomena he differentiates one type wherein certain unrecalable, distressing, past experiences are relived repeatedly without the subject's cognizance of this fact. These experiential replicas are produced by a detectable unconscious activity. It is driven, Freud believes, by endogenously generated energy because 'ingenuity' is unconsciously employed to relive 'all of these unwanted situations and painful emotions' and because '... they are repeated, under pressure of a compulsion' (1920, p. 21). Such endogenous stimulation of the replica-producing activity distinguishes repetition compulsion reliving from exogenously stimulated reliving, such as occurs, for example, with conditioned reflexes. Replica-producing activity is aimed, Freud believes, at re-experiencing re-

peatedly certain unrecalable events. This enigmatic, unconscious aim distinguishes repetition compulsion from recurrent phenomena with a different aim.

Replica production is of theoretical interest because of unique clinical features described by Freud as:

'... a new and remarkable fact, namely that the compulsion to repeat also recalls from the past experiences which include no possibility of pleasure, and which can never, even long ago, have brought satisfaction even to instinctual impulses which have since been repressed.' (1920, p. 20)

'... it might be supposed that they would cause less unpleasure to-day if they emerged as memories or dreams instead of taking the form of fresh experiences.' (1920, p. 21).

On the basis of these clinical features, which Hartmann (1937) calls the manifestations of fixations on traumata rather than on gratifications, Freud makes the following crucial decision:

'If we take into account observations such as these, based upon behaviour in the transference and upon the life-histories of men and women, we shall find courage to assume that there really does exist in the mind a compulsion to repeat which overrides the pleasure principle.' (1920, p. 22).

With this inference, repetition compulsion activity is relegated to a newly conceptualized category of psychological phenomena. The activity is not an instinctual drive representative of the type described before 1919. It is not an aspect of ego functioning, either defensive, such as resistance against lifting repression, or non-defensive, such as learning (Hartmann, 1937, p. 98), mastery and automatization (pp. 95-96).

Nor is it a manifestation of identifications with fear-evoking aggressors or with love-inspiring objects (Freud, 1917, 1923). As Hartmann puts it (1937, pp. 95-96), the compulsion to repeat is differentiated from the wish to repeat, and the repetition of experiences is differentiated from the repetition of methods of solution.

Freud cautions that mental phenomena with repetition compulsion activity determinants are usually moulded also by varying admixtures of other determinants pressing for discharge. He writes:

'... only in rare instances can we observe the pure effects of the compulsion to repeat, unsupported by other motives ...'

'... the compulsion to repeat and instinctual satisfaction which is immediately pleasurable seem to converge here into an intimate partnership.' (Freud, 1920, p. 23).

In seeking the source of repetition compulsion activity, Freud notes that it is driven by endogenously generated pressure, utilizes primary processes for discharge (1920, p. 36), and operates independently of pleasure-unpleasure considerations. Concluding that an activity with such characteristics cannot be a manifestation of ego functioning but must be a representative of instinctual drives, he writes:

'For it is possible to recognize the dominance in the unconscious mind of a "compulsion to repeat" proceeding from the instinctual impulses and probably inherent in the very nature of the instincts ...' (Freud, 1919, p. 238).

'... the compulsion to repeat must be ascribed to the unconscious repressed ...' (1920, p. 20) ... (and not to the) 'coherent ego' (p. 19) ... (including its unconscious resistances).

'The manifestations of a compulsion to repeat ... exhibit to a high degree an instinctual character.' (p. 35).

Profoundly impressed by the observation that repetition compulsion activity is not regulated by the pleasure-unpleasure principle, and by the inference that the activity is none the less an instinctual drive representative, Freud explores regions previously uncharted. He conceptualizes a new category of drive representatives arising from a primitive organization of drive processes whose discharge patterns are not modified by pleasure-unpleasure considerations. Representatives of these primitively organized processes, in so far as they override the pleasure-unpleasure principle, are inferred to be more powerful than the oral, anal, phallic and genital drive representatives described before 1919 and

arising from a more evolved organization of drive processes. How discovery of repetition compulsion activity enables Freud to sense the operation of the newly-formulated drive process organization is conveyed in the following passages:

'Enough is left unexplained to justify the hypothesis of a compulsion to repeat—something that seems more primitive, more elementary, more instinctual than the pleasure principle which it overrides.' (1920, p. 23).

(Special anxiety dreams associated with reliving) ... '... thus afford us a view of a function of the mental apparatus which, though it does not contradict the pleasure principle, is nevertheless independent of it and seems to be more primitive than the purpose of gaining pleasure and avoiding unpleasure.' (p. 32).

'The manifestations of a compulsion to repeat ... when they act in opposition to the pleasure principle, give the appearance of some "daemonic" force at work.' (p. 35).

Focussing next on the observable genetic relationship between certain disruptive experiences early in life, amnesia thereof, and repetition compulsion activity, Freud investigates the relations of his clinical triad to stimulus barrier preservation, perception, and memory trace formation. First he notes that every registered stimulus of an intensity within limits set by stimulus barrier organization permanently modifies mental structure by a specific, normal process without disrupting overall mental organization. This modification, manifest psychologically as a normal memory trace composed of phase specific mental representations, is described as follows:

'It may be supposed that, in passing from one element to another, an excitation has to overcome a resistance, and that the diminution of resistance thus effected is what lays down a permanent trace of the excitation, that is, a facilitation.' (1920, p. 26).

Then he traces out how a stimulus of an intensity exceeding stimulus barrier limits disrupts normal perception, representation and memory trace formation (1920, pp. 24-36). Such disruption of vital mental processes evokes survival type defences. These are manifestations of a newly activated (Jackson, 1958), newly dominant, archaic functional organization that, partly because of its primitiveness, has escaped disruption by the traumatizing stimulus. The functioning of this restructured organization, aimed towards preserving integrity on the less evolved level, has operational features that are

neither regulated nor deflected by pleasure-unpleasure aspects. The traumatizing stimulus is not registered adequately as a memory trace of usual and normal form, because it has impaired the usual and normal processes of perception, representation, and memory trace formation. But the traumatizing stimulus is registered definitively by the actual form of the deviant mental organization jointly established by the disruption and by the instinctual defences this disruption evoked. Such registration has characteristics that differ from those of the usual memory trace. For instance, registration by regressive restructuring entails sustained, uncontrollable, deviant functioning. Moreover, because such registration is produced by processes that do not employ mental representations, it is not available for recall.

Freud continues by noting that after the traumatizing stimulus ceases, processes associated with the impaired, higher level of functional organization press to restructure the deviant mental organization and to reinstate normally organized structured functioning. These processes also are neither regulated nor deflected by pleasure-unpleasure aspects. Their operation apparently entails re-experiencing attenuated versions of the disruptive experience until adequate representations of it are finally formed. Such endogenously directed reliving is manifested clinically as repetition compulsion activity.

II. *Repetition Compulsion as an Empirical Entity*

These observations and inferences have subsequently been investigated by others (Bibring, 1943; Hartmann, 1937; Hendrick, 1942; Jacobson, 1953; Kubie, 1939, 1941; Nunberg, 1937; Schur, 1960). Their findings are discordant. Many investigators are opposed to a concept such as beyond the pleasure principle. They consider recurrent disagreeable phenomena as manifestations of unconscious id masochism, superego sadism, or ego functioning that is either non-defensive, such as mastery, learning, and damage restitution, or defensive, such as repression, identification, and acting-out. All such id, superego, and ego productions are regulated either by the pleasure-unpleasure principle or by its extension, the reality principle. These investigators do not believe that the repetition compulsion is clinically detectable.

Cognizant of critiques such as these, this reinvestigation utilizes clinical data from

analyses in an attempt to answer these questions: 'Does the repetition compulsion exist as an empirical entity?' (Kubie, 1939, p. 397). 'If it does exist, what are the operational features of the unconscious activity producing it?' 'What is the activity's source and function?'

Of the various types of repetitive phenomena observed in the course of analyses, there is one comprising several recurrent, disagreeable experience complexes. Each complex is made up of an unfolding sequence of stereotyped states of mind or phases, which, when lived-through in the course of successive editions, eventually evoke recall of previously unremembered, identically structured, past experiences. The interaction between recurrent stereotyped phases and patient may be considered from two aspects. Viewed from one angle, the states of mind imposed upon and enveloping the patient are observed to be produced by an endogenously driven, unconscious activity. Viewed from another angle, the patient living-through editions of phase sequences is observed to be endogenously impelled to perceive and represent them. The existence of this impulsion to register is demonstrated clearly on occasions when it is insistent. At such times, the patient, despite his substantial wish to avoid unpleasure and to seek pleasure, is observed to forego readily available id gratifications and ego defences and to permit prolongation of the disagreeable state in order better to delineate it. As these interactions gradually evoke one new memory after another of prototype pathogenic experiences, it becomes increasingly evident that the replica-producing activity and the registering activity are manifestations of a process aimed towards reorganizing structured functioning in such a way that amnesias resolve.

The replica-producing activity is observed to operate in the following manner. As a patient experiences his momentary mental state, he consciously, preconscious, and unconsciously (Fisher, 1954, 1956) perceives, *in statu nascendi*, various aspects of his momentary mental life and external environment. His perceptions are given conscious, preconscious, and unconscious representations. These and their associations evoke complex responses that, sooner or later, usher in a new dominant organization of functioning, characteristic of the first phase of an experience complex. The phase's mental functioning and mental elements are registered and subsequently replaced by newly evoked functioning and elements, characteristic of the next phase in the

sequence. In the course of time the entire experience complex and successive editions thereof are lived-through, during which each recurrent state of mind is perceived, delineated, and represented with increasing intricacy and comprehensiveness.

In some essentials, these perceptual processes and their sequelae are similar to those described by Fisher (1954, 1956) in studies on conscious, preconscious, and unconscious perception of visual stimuli tachistoscopically introduced. Both approaches, the clinical and the experimental, lead to findings in harmony with the conclusion that fleeting stimuli, even if registered and represented only in an unconscious way, may evoke, by associational pathways, alterations in functioning, including memory, and alterations in mental elements produced, including memory traces. A fundamental dissimilarity in the two approaches is that, with the replica-producing activity, the endogenously produced experiential stimuli always have a very intense, condensed cathexis; whereas with tachistoscopic stimulation, the exogenously introduced, arbitrary visual stimuli have meaning and cathexis related to the subject's representations of the experiment and the investigator. Replica-producing activity stimulation evokes an integrated and evolving response. Tachistoscopic stimulation generally evokes an isolated and limited response.

The aforementioned refinement and elaboration of a phase's specific features and associational ties are vitally enhanced by the analytic process, which concomitantly separates, dismantles, and removes determinants arising from the usual unconscious drive representatives, ego defences, and superego imperatives. When, after a variable number of editions, the refinement and elaboration have become sufficiently specific and detailed, one observes that experiential stimuli of a current phase suddenly evoke, 'out of the blue', conscious representations of a vital aspect of a previously unremembered, highly cathected experience. These conscious representations, as well as associated preconscious and unconscious representations may conform to a mode of representing that was appropriate to the structured functioning existent when the original experience occurred. Or these representations may be translations by current cognition of an early-life mode of representing and thereby they conform to a current mode of representing. Or they may comprise a screen memory (Freud, 1899) of varying com-

plexity. These variations in representational and cognitive modes are determined by such processes as have been described in Freud's concepts of primary (1900, pp. 603-604) and infantile repression (1915), Isakower's (1938) observations on the revival in sleep of early-life states of mind, Lewin's (1953) studies on dream screen phenomena, Hoffer's (1949, 1950) descriptions of infantile ego organization, and Spitz's (1955) analysis of primal cavity experiences.

The replica-producing activity is observed to conform to one of these three patterns as it creates states of mind sufficiently detailed and intense to evoke increasingly intricate and integrated representations:

In pattern 1, the replica-producing activity unconsciously directs the patient's attention to perceive current internal milieu or external environment from some special angle. This leads to representations that evoke, initially, alterations in state of mind and structured functioning, and subsequently, in some later edition, memories of an early-life experience with similar state of mind and structured functioning. For example, the replica-producing activity may drive the patient to focus selectively on certain minor details pertaining to the analyst and thereby activate a mental state later identifiable as a replica. Or this activity may unconsciously so cathect certain ideas, memories, dreams, affects, or actions that they attract the patient's attention and thereupon precipitate responses that comprise a replica. Or this activity may drive the patient unconsciously to alienate his employer or coworker and with such provocation set off a chain reaction reproducing the unrecallable past.

Pattern 2 emerges when the current internal milieu and external environment do not provide the constellation of stimuli needed to evoke a replica with new, more detailed differentiation, that approximates more closely the subtle configurations of the prototype experience. In such circumstances the replica-producing activity unconsciously drives the patient to interact with some aspects of the current multifaceted external environment and to avoid other aspects. This selectivity gradually transforms the external environment until it contains or yields on simple provocation the constellation of stimuli needed to evoke a more elaborated reliving experience. For example, the patient unconsciously may use all the means at his disposal, within limits of adequate reality testing, to transform the

analysis and analyst into some special cast. By actually making the analysis a stagnant or a disruptive entity or by actually rendering the analyst ineffectual, the patient creates new circumstances which contain the specific constellation of stimuli required. In non-analysands this pattern produces the 'fate neurosis' described by Freud (1920, p. 22). The following fragment from an analysis illustrates pattern 2 activity operating outside of the analytic relationship:

The patient was unconsciously driven first to usurp the role of his apartment house superintendent by getting permission from the owner to set the colour scheme of the lobbies and elevator, and then to usurp the role of the house painter by surreptitiously touching up the painter's poor work on the elevator ceiling. While so doing he 'accidentally' used paint that did not blend, and therewith brought his deed to the attention of all the people in the house. Following his first usurpation, he believed that the superintendent, angered over being displaced, suggested to the other tenants to regard the new decor and its contriver with disfavour. Following his second usurpation, he believed that all the other tenants suspected who had meddled with the painter's work. In the newly transformed situation he experienced that his identity in the minds of his neighbours and others concerned was actually confused, and that they now related to him with manifestations of their confusion.

This experience evoked in him a distressing state of mind, characterized by despair, anger, and identity confusion; and then it revived, by means of this state, memories of how his mother, throughout his childhood, called him first by his older brother's name and then corrected herself and called him by his own, saying: 'John . . . er . . . oh . . . Henry.'

Living-through these experiential replicas, representing them, and finally recalling the early-life prototypes, promoted formation of new representations of various internal and external aspects of his childhood.

The more normal the individual's reality testing, the more stringent are the limits, internally set, on operations of the replica-producing and registering activities. With pattern 1, there are limits to the degree of reality distortion permitted in the formation of unique representations. With pattern 2, there are limits to the nature of the actions actually undertaken in the course of the unconscious attempt to transform external reality. Psychotics are less stringently limited by reality considerations. They have a freer hand in forming representations and in transforming their environment. For them pattern 1 provides many perceptions and repre-

sentations that are actually misperceptions and misrepresentations in forms such as illusions, delusions, denials, and hallucinations. Although misperceptions and misrepresentations, they none the less evoke re-experiences reproducing early-life experiences. A lucid illustration of this is Niederland's (1959) demonstration that many of Schreber's psychotic experiences were highly accurate replicas of actual bizarre experiences he was forced, by his parents, to live through during his earliest years.

Pattern 3 emerges when internally set limits or external limiting factors do not permit the actual transformation of the external environment into one containing the specific constellation of stimuli required to evoke more elaborated phases. Generally, such a situation arises when the required stimuli are too discordant with such substantial needs as self-preservation or else are so alien to the make-up of the current environment that they cannot be built into it. An example of the latter is a pathogenic experience during early life occurring in and linked to a peasant society in rural Russia, and replica-producing activity operating during adulthood in the setting of urban New York City. With pattern 3, the replica-producing activity is introverted. It acts upon and alters the very processes that underlie functioning, and in so doing produces functional abnormalities. These impairments, when experienced and registered, first evoke states more elaborated than hitherto and then new memories. For example:

A man at the start of an analytic session says: 'I had a thought on lying down. It is simple enough. I have tried to tell it to you half a dozen times during the past few minutes. I cannot. I don't know why, but it is impossible to. This makes me feel very impatient with myself. I feel so stupid.'

In this incident and subsequent editions thereof, the patient experiences first a temporary impairment in his ability to describe what comes to mind and then the diverse affects and representations evoked by living-through this impairment.

Analysis of this experience complex whenever it recurred led to discovery of various underlying determinants, including: (a) unconscious anxiety-ridden impulses related to transference love; (b) unconscious guilt-ridden impulses related to transference hate; and (c) increasingly active memories of similar experience complexes which involved analogous impairments and which occurred during certain early-life interactions with his parents. In these childhood experiences, his attempts to communicate to his parents certain reality-oriented observations and ideas were not successful because of the blocking effect of his parents' massive denials,

isolations, and delusions. Such experiences of communication failure evoked in the little boy a nexus of mental elements comprising states of disappointment and confusion, feelings of despair and anger, and ideas of defectiveness. To defend against such disorganizing experiences, complex functions gradually developed that inhibited both consciousness and communication of his spontaneous ideational flow and that reworked newly emerging ideas so that they could be comprehended by his parents despite their pathological constrictions.

The currently experienced replicas of the early-life prototypes enabled him, for the first time, to form certain crucial representations about himself and his parents. As these new representations were worked-through and integrated, the replicas recurred with less frequency and intensity. Each subsequent edition that did occur, however, conveyed new significant information about the prototype.

It is noteworthy that replica-producing activity's introverted discharge, in its thrust to construct an experiential replica, has the power to impair ego functioning. In so doing it overrides various powerful counterforces operating in this patient, such as his need to maintain integrity of his ego functioning; his wish to win the analyst's love by 'free-associating' faultlessly; and his impulse to denigrate the analyst by exhibiting a mental prowess second to none.

Discharge via pattern 3 is a frequent cause of malfunctioning in perceptual, cognitive (Keiser, 1962), affective, and motoric spheres, and also of abnormal states of mind accompanying conditions such as fugues (Lipin, 1960) and ruminating binges. When replica-producing activity discharge is directed upon processes that underlie somatic functioning, it produces somatic malfunctioning. Living through the somatic symptoms that arise evokes replicas of unremembered early-life experiences of physiological malfunctioning related to disease, injury, congenital abnormality, or neglect. Such 'somatic memories' (Lipin, 1955) are produced by physiological abnormalities that differ from those responsible for the prototype, early-life somatic malfunctioning. Although the symptoms are reproduced, the etiological pathology usually is not. Therefore, the current physical and laboratory findings differ from the original findings. In another variation of pattern 3, an unremembered early-life experience with a love object is relived in the form of an internalized experience generated by inter- or intrasystemic interactions. For example, replica-producing activity's unconscious activation of impulses which will conflict with ideals, or opinions

which will elicit dissonant judgements, may evoke and recreate the state of mind specifically associated with an unremembered early-life interpersonal conflict. In general, inter- and intrasystemic interactions generated by replica-producing activity differ metapsychologically from such introverted discharges associated with unconscious instinctual drive representatives under pleasure-unpleasure principle regulation. The latter category of internalized discharges comprises id activity, such as, for example, introverted sado-masochism (Freud, 1924), and ego-superego activity (Freud, 1900, pp. 557-558), of a type discharging internally in reaction to externally directed drive representatives.

Briefly recapitulated, pattern 1 involves unconscious utilization of currently available internal and external stimuli for unconscious construction of experiential replicas; pattern 2 involves unconscious transformation of external reality so that previously absent, required stimuli become available externally; pattern 3 involves unconscious transformation of internal milieu so that previously absent, required stimuli, too dangerous or too bizarre for external materialization, become available internally. Incidentally, the work and energy expended in replica construction increases substantially with each successive pattern in the above sequence.

These observations on *select* repetitions and on their underlying unconscious activities are in harmony with the following conclusions:

(1) Each repetitive experience complex is an experiential replica of a stressful experience whose essentials are unrecallable.

(2) Recurrent replicas are produced, despite attendant distress, by an endogenously organized and driven unconscious activity having any of three operational patterns.

(3) Replica re-editions, especially those occurring in the analytic therapeutic alliance, tend towards increasing differentiation of details experienced and represented by the analysand.

(4) When differentiation has progressed sufficiently, the form of memory registration of the prototype stress is altered. Registration as distorted structured functioning is transformed into registration as memory trace representations.

(5) Transformation of memory registration; concomitant decline of further replica production; and ensuing improvement in mental health are clinically observable signs of an active restructuring process and of reorganized structured functioning.

(6) Replica production is a manifestation of a restructuring process aimed towards undoing structural distortions that follow certain stressful experiences. In so far as the restructuring process presses for normal structured functioning, replica production is not related primarily to those phase-specific id derivatives that are regulated by the pleasure-unpleasure principle, or to ego defences, or to strivings to attain ideals and obey prohibitions of the superego.

These findings and inferences support the view that the select repetitions and their underlying unconscious activities are empirical entities, detectable clinically. Because they were discovered and first investigated by Freud, they will be referred to respectively as the repetition compulsion phenomenon and repetition compulsion activity.

The restructuring process underlying repetition compulsion activity brings into perception replicas of past experiences having primarily unconscious registrations much as the dream process brings into perception representatives of unconscious wishes. In both instances derivatives of unconscious mental elements succeed in impinging on perception through the operation of the process of cathectic displacements (Freud, 1900, p. 553). In the case of the restructuring process, a perceivable facsimile of unconscious registrations is constructed by selective cathexis of recently formed representations. Perception and representations of the facsimile evoke discharge of impulses, some of which are unconscious. Experiencing these discharges leads to the formation of representations that effect reorganization of structured functioning. In the case of the dream process, a perceivable representative of unconscious wishes is constructed by selective cathexis of recently formed representations. Perception and representations of the representative evoke discharge of impulses, some of which are unconscious. Experiencing these discharges leads to the formation of representations that effect continuation of the state of sleep (Freud, 1900, pp. 570, 578-9) which is necessary for normally operating structured functioning.

On the basis of other observations, it is likely that perception and representations of the experiential replica are not merely utilized but are actually required for restructuring-process operation. Freud reports that suitable representations are indispensable for the operation of some processes. For example, in the seventh chapter of *The Interpretation of Dreams* he writes that:

'... an unconscious idea is as such quite incapable of entering the preconscious and [that] it can only exercise any effect there by establishing a connection with an idea which already belongs to the preconscious, by transferring its intensity on to it and by getting itself "covered" by it.' (p. 562).

The opportunity to construct, experience, and represent increasingly differentiated replicas is much greater in analysis than in daily life because the special features of the therapeutic alliance promote and safeguard restructuring-process operation. In contrast, the process's successful operation outside of analytic protection and intervention is frequently impeded by complications it creates; so that instead of evoking memories it often provokes disasters. These extend the pathogenic core associated with the prototype stress and further distort structured functioning.

III. *Repetition Compulsion and Instinctual Drive Representatives*

The source of repetition compulsion activity is as controversial as is the description of the activity's clinical features. Some investigators find, as does Freud, that the activity is associated primarily with structural distortions and structural restitutions. They conclude, as does Freud, that it is an instinctual drive representative. Others find that the activity is associated primarily with actively mastering a passively experienced event or with learning. They conclude that it is an ego function. Before reinvestigating this matter it may be clarifying to outline some concepts pertaining to the biological wellsprings of mental activity.

The concept of instinctual drives, as the basic determinant of an organism's characteristics, is linked to the concept of biological processes establishing functions that are organized into successive developmental hierarchies. 'Instinctual drive' and 'biological process' are complementary concepts; each produces and each mediates the other. Freud (1905, p. 168) conceptualizes instinctual drives as '... lying on the frontier between the mental and the physical'. As a corollary, an instinctual drive may concomitantly have physiological and psychological representatives. Operational characteristics of drives are inferred from observations on endogenously driven phenomena occurring in specific zones of operation (Freud, 1915a). Empirically, drive discharge patterns usually fit well into their pertinent milieus. This is conceptualized in

Darwinian terms as the consequence of evolutionary adaptation of structured functioning to the average expectable environment (Hartmann, 1937, p. 23). Empirically, structured functioning on one maturational level suppresses lower level functional organizations. This is conceptualized for the body in Jacksonian terms (Jackson, 1958) as physiological inhibition, and for the mind in Freudian terms as psychological repression (Freud, 1900, pp. 603-4). Empirically, disruption of dominant structured functioning reactivates dominance of the next lower functional organization. This is conceptualized for the body in Jacksonian terms as physiological release, and for the mind in Freudian terms as psychological regression or freeing '... from an inhibition' (Freud, 1900, p. 605).

In the realm of human psychology, empirical data on instinctual drives are obtained from observations on mental phenomena for which there is evidence of endogenously generated excitation (Freud, 1915a) discharging under specific conditions as an endogenously structured pattern (Freud, 1905, pp. 128, 168; 1915a). Once the characteristics of a postulated drive are formulated in sufficient detail, all detectable manifestations attributed to the drive's activity are considered its representatives. Psychological representatives of drives may be divided into two categories: one entailing drive cathexis of a mental element; the other, drive cathexis of a mental function.

Drive cathexis of mental elements is conceptualized by Freud in terms such as:

'An instinct can never become an object of consciousness—only the idea that represents the instinct can. Even in the unconscious, moreover, an instinct cannot be represented otherwise than by an idea. If the instinct did not attach itself to an idea or manifest itself as an affective state, we could know nothing about it.' (1915c, p. 177).

(An instinctual representative is) '... an idea or group of ideas which is cathected with a definite quota of psychical energy ... coming from an instinct.' (1915b, p. 152).

In this concept a percept, memory, idea, affect, impulse or other mental element produced by mental functioning is also a drive representative if a drive has a special connexion with it or energy investment in it because the mental element promotes discharge of the drive. Mental elements cathected by a drive are progressively organized along an endogenously structured pattern until the end-point of the pattern is attained and discharge of the endogenously

generated energy of the drive occurs. If mental elements crucial for the attainment of a pattern's organization and end-point do not exist, drive discharge via the specific pattern concerned cannot occur. A deficiency of mental elements essential for development of a specific discharge pattern not only blocks drive discharge via that pattern but also leads to conditions wherein drive cathexes are displaced onto other mental elements and drive discharge occurs via other patterns.

Drive cathexis of a function provides the function's energy and determines its operational features. A portion of a function's drive cathexis and resultant operational features stems from biological processes. Such processes do not employ mental representations. Alterations in these processes alter the function's drive cathexis and thereby modify its operational features. From this angle, even those functions performing psychological operations and producing mental elements are not psychological drive representatives. They are physiological drive representatives. But, in so far as functions are experienced, they are registered as conscious, preconscious, and unconscious representations. These representations become, in varying degrees, the locus of diverse discharging psychological processes. And it is known from observations on conversion hysteria (Freud, 1893-1895) and other forms of internalized discharge (Freud, 1924, 1926) that when psychological processes discharge upon a function's representations, the actions of the function's physiological drive cathexis are altered, and consequently the function's operation is altered. Therefore, a portion of a function's drive cathexis and resultant operational features stems from psychological processes. To the extent that the momentary status of a function's operation is moulded by psychological processes cathecting representations of the function, its operational features are psychological drive representatives.

Freud's investigations (1900, 1915a) of those drive discharge patterns that relate to maintenance of phase-specific structured functioning, demonstrate their manifold vicissitudes. The extraordinary plasticity in humans of the discharge patterns of such drives is regarded (Hartmann, 1948) as an indication of the highly evolved structured functioning that comprises the ego.

The tension build-up and discharge of drive patterns occur within limits inherent in every

physiological and psychological organization. The demonstrable existence of such limits is the basis for the inference that there are structuralized regulating processes or principles (Hartmann, 1937). Such regulators are representatives of those drives that form and maintain organizational integrity. In physiology, regulators detected by chemical, electrical, and mechanical methods are grouped together by Cannon's integrated concept of homeostasis (Cannon, 1932). In psychology, regulators detected in metapsychological contexts of dynamics, energetics, structure, adaptation, and genesis (Hartmann, 1937) are delineated by Freud's concepts of constancy principle, pleasure-unpleasure principle, and reality principle. Constancy principle (Freud, 1915a, 1920; Hartmann, 1937) refers to the range between upper and lower limits of the quantity or tension of drive energy characteristically operative in the normally functioning mind. Pleasure-unpleasure principle (Freud, 1911, 1920; Hartmann, 1937) refers to the subjective or qualitative aspects of every experience and to the powerful dynamic effects of such subjective aspects on drive discharge vicissitudes. Reality principle (Freud, 1911, 1920; Hartmann, 1937), a regularly arising specific developmental elaboration of the pleasure-unpleasure principle, refers to the limits imposed by reality on the fitting-in of drive discharges and their operational milieus. The concept of regulators is subordinated to the concept of a phylogenetic hierarchy of biological organizations, each uniquely adaptive in its own way to the environment. Because of this subordination, a regulator evolved to help maintain integrity of a highly evolved organization may not exist in a less evolved organization.

A clinically detectable unconscious activity that is endogenously driven may be primary, in which case it is an instinctual drive representative; or secondary, in which case it is some unconscious ego or superego function responding to excitation of an associated instinctual drive representative. Both primary and secondary endogenous activities utilize any function of the id, ego, or superego (Freud, 1923, 1924a) that furthers their aim; and both types are regulated by the constancy principle. The organization of a primary activity, however, is structured by biological processes utilizing physiological mechanisms, whereas the organization of a secondary activity is structured by psychological ego-superego functions utilizing mental elements. Determining the source of an

endogenously driven, unconscious activity, such as repetition compulsion activity, requires the elucidating of the activity's organization in terms of discharge pattern and end-point. If pattern and end-point are structured primarily by processes that do not utilize mental representations, the activity is presumed to be a manifestation of biological processes. It may be considered an instinctual drive representative. If pattern and end-point are structured primarily by processes that utilize representations and that are responsive to representations of pressing stimuli arising internally or externally, the activity is presumed to be a manifestation of psychological processes. It is an ego or superego function.

In the framework of these concepts, what can be said about the source of repetition compulsion activity as it is observed in the special conditions of the analytic therapeutic alliance? Early in an analysis the activity is perceived only impressionistically. It appears in a *mélange* of intertwined, diverse mental activities; a conglomeration of id, ego, and superego functions as well as primary and secondary process operations. As the analysis progresses, there is a gradual abatement of preemptory primary process activities that tend to utilize contents of current states of mind for discharge of manifold unconscious impulses. The patient's perceptive, integrative, and communicative abilities improve, and are harnessed increasingly by the therapeutic alliance. The diverse mental activities appear in progressively purer culture; their differentiation and delineation in depth become increasingly feasible. With this sharpening of focus, the detectable pattern and end-point of repetition compulsion activity regularly have the following organization: (a) the discharge pattern entails recurrent replica formation wherein certain unremembered stress stimuli, registered unconsciously in an unusual form, repeatedly impinge upon perception; (b) the end-point entails a mental restructuring characterized partly by conversion of the unusual registration into usual memory trace representations. Such pattern and end-point have no demonstrable relation to the subject's representations of inner and outer reality or of ideals and prohibitions. But they have a demonstrable relation to the restructuring mentioned, which more closely approximates hierarchical organization as it is normally structured by biological processes. On the basis of these inferences which discount the structuring

of the activity by psychological functions and favour its structuring by biological processes, it is postulated that repetition compulsion activity is an instinctual drive representative.

This particular drive representative, when compared with all drive representatives described before 1919, is unique insofar as its discharge pattern is highly resistant to modification by considerations of pleasure or displeasure. This relative unmodifiability by ego and superego functioning is a clinical sign that the underlying drive process of repetition compulsion activity is organized on a level of the biological hierarchy lower than that of drive processes whose patterns and representatives are more easily modified. This drive process is aligned with processes that produce, as accurately as circumstances permit, progressive maturational unfolding of structured functioning, according to an innate genetic blueprint and timetable, until adult organization comes about. Their discharge patterns, effecting scheduled shifts in structured functioning in the service of accurate construction, are rather rigidly fixed. Consequently their psychological representatives, appearing in configurations specific for each developmental stage, demonstrate only slight vicissitudes related to seeking pleasure and avoiding displeasure. In contrast, drive processes organized on the higher biological level maintain integrity of phase-specific structured functioning as effectively as circumstances permit. Their discharge patterns, providing phase-appropriate functioning in the context of tension reduction by pleasurable means, have remarkable plasticity. Consequently their psychological representatives, appearing in configurations specific for each maturational phase, demonstrate extensive vicissitudes related to seeking pleasure and avoiding displeasure.

In recognition of these fundamental differences concerning biological level of organization, operational aim, discharge regulation, and pattern flexibility, it may facilitate further investigation to classify those instinctual drive representatives primarily related to maturational restructuring processes (Freud, 1900, p. 603) as 'maturational' drive-representatives, and those primarily related to processes maintaining a phase's structural integrity as 'structural' drive-representatives. Freud implies this differentiation in *Three Essays on Sexuality* (1905). His libido theory describes the characteristic organization of each psychosexual phase in the unfolding developmental pattern of sexual

(and aggressive) drive representatives. Although each new phase in this developmental sequence is organizationally higher than prior phases, all the phases nonetheless stem from drive processes organized on those higher biological levels wherein discharge is regulated by both constancy principle and pleasure-unpleasure principle. By elucidating this developmental sequence, Freud (1900, p. 585) uncovers the existence and operation of (sexual and aggressive) drive processes that produce it. These processes are organized on those lower biological levels wherein discharge is regulated only by the constancy principle. Under the proposed terminology, the latter processes give rise to maturational drive-representatives; the former to structural drive-representatives. Using psychoanalytic techniques to differentiate between (a) drive phenomena associated with scheduled maturation of a newborn's mind into an adult's, and (b) drive phenomena associated with specific functioning of a maturational phase, is analogous to using biological techniques to differentiate between (a) developmental processes of embryology and growth, and (b) physiological processes specific for infancy, childhood, adolescence, adulthood, and senility. In the context of the suggested classification, the repetition compulsion phenomenon and activity are maturational drive-representatives.

IV. Repetition Compulsion and Maturational Drive-Representatives

Information on processes bringing about mental development comes from observations on shifts of maturational phases. Each shift of structured functioning is conceptualized (Hartmann, Kris and Loewenstein, 1947, p. 18; Spitz, 1959, pp. 10-14, 34; Hartmann, 1937, pp. 48-56), as the blended product of maturational drive-representatives and phase-specific functions, especially learning, defending, synthesizing, and sublimating. Maturational drive-representatives reflect phylogenetic history; phase-specific functions reflect ontogenetic history. Maturational drive-discharges are insistent and conform to a biological schedule, as the following illustration by Freud, based on the dissolution of the Oedipus complex, emphasizes:

'Another view is that the Oedipus complex must collapse because the time has come for its disintegration, just as the milk-teeth fall out when the permanent ones begin to grow. Although the majority of human beings go through the Oedipus complex as an individual experience, it is nevertheless a pheno-

menon which is determined and laid down by heredity and which is bound to pass away according to programme when the next pre-ordained phase of development sets in.'

'There is room for the ontogenetic view side by side with the more far-reaching phylogenetic one.' (1924, pp. 173-174).

Maturational shifts of structured functioning involve body and mind. In some instances, such as dissolution of the Oedipus complex, mental reorganization is more apparent than bodily. In the above illustration, Freud highlights the decathexis and repression of psychological functioning so organized to appear as the Oedipus complex, and implies the shift of cathexis onto psychological functioning so organized to appear as the latency period. In other instances of developmental restructuring, such as those occurring in the earliest years of life, in puberty, and in the involutional period (Freud, 1937, p. 327) mental and bodily reorganizations are equally apparent. It is probably a misconception, introduced by the older phenomenological techniques which detect somatic reorganizations more readily than psychic ones, to consider maturational drive-representatives as primarily involving somatic changes, with psyche hurrying along behind attempting to cope with and integrate the new somatic organization. The newer, psycho-analytic techniques provide a more accurate view, in harmony with the alternative concept that discharging maturational drive-representatives contemporaneously reorganize soma and psyche. An illustration of coincident restructuring of body and mind is provided by Greenacre, who writes:

... one must recall that during the first few months, roughly the first six, the mouth and lips seem undoubtedly to be the focus of the most differentiated and sensitive sensations and are used for pleasure and exploration above any other body part. They furnish the paradigm for other incorporations. In addition tactile sensations (warmth, stroking, firm holding) supplemented by superficial kinesthetic responses and smell probably furnish the bulk of the sensory life of the infant, with hearing and vision playing extremely variable roles.

'With the sitting up of the child and development of the focusing of the eyes and more precise arm and hand movements, much of the exploratory activity of the infant is switched from the mouth to prehensile vision and arm-hand activity. That the ratio of participation of orality-vision hand-touch must vary considerably in different infants is obvious. It might parenthetically be suggested, however, that

the differences in these ratios are extremely fateful in contributing to the forms of later development.' (Greenacre, 1953, pp. 90-91).

Investigators of developmental shifts emphasize repeatedly that certain experience complexes, specific for each developmental stage, must actually be lived-through if the individual is to mature normally. The following are some pertinent excerpts:

Kris: '... the lack of adequate object relationship in infancy may threaten the infant's life, may cause serious and even irreversible changes in areas of maturation and create psychosomatic disturbances, the extent and impact of which is not as yet fully known.' (1950, p. 31).

Hartmann, Kris and Loewenstein: '... partial deprivation thus is probably an essential condition for the infant's ability to distinguish between the self and the object.' (1947, p. 20).

Greenacre: '... the deficient handling or cuddling of the child gives it inadequate surface stimulation and warming, and the body surface may not be well defined or secure in the central image.' (1953, p. 90).

Mahler: 'The turning from predominantly proprioceptive awareness to increased sensory awareness of the outer world occurs through the medium of affective rapport with the mother.' (1952, p. 287).

Mahler and Elkisch: 'This object finding of the own body in turn seems a pre-requisite for rendering the outside object fit for identification by projective and introjective identification mechanisms.' (1953, p. 219).

Jacobson: '... early infantile affecto-motor identifications seem to precede and usher in imitations of the parents' functional activities.' (1954, p. 100).

Freud: 'The broad general outcome of the sexual phase dominated by the Oedipus complex may, therefore, be taken to be the forming of a precipitate in the ego, consisting of these two identifications in some way united with each other. This modification of the ego retains its special position; it confronts the other contents of the ego as an ego ideal or super-ego.' (1923, p. 34).

Winnicott: 'If maternal care is not good enough then the infant does not really come into existence, since there is no continuity of being; instead the personality becomes built on the basis of reactions to environmental impingement.' (1960, p. 594).

By living-through experiences essential for normal development, phase-specific percepts and representations are formed which excite and promote discharge of maturational drive-patterns specific for the developmental stage. Maturational drive-patterns are organized biological processes, driven by endogenously generated energy, and established phylogenetically

by evolutionary processes fitted into the average expectable environment. When their discharge is triggered by percepts and representations supplied by the average expectable environment, latent impulses and capacities, organized by biological processes, are brought into actual operation for the first time. Spitz (1959) refers to the triggering percepts and representations as 'key stimuli' needed during 'critical periods' of development. Hartmann (1937, p. 35) calls them 'environmental releasers'. The biological discharge patterns, the triggering percepts and representations, and the actualized impulses and capacities are maturational drive-representatives.

When new impulses and capacities are actualized by biological processes, their experiential features are perceived, represented, elaborated, and synthesized by psychological processes. This psychological working-through promotes orderly actualization of other impulses and capacities still in latent form. When the sequential unfolding of maturational drive-representatives has progressed sufficiently, a new overall integration of structured functioning appears, acquires dominant cathexis, and a new maturational phase sets in. The mental organization of the prior phase not only loses cathexis, but also is actively repressed (Freud, 1900, p. 603) in the interest of operational coordination. According to Erikson (1950 pp. 30-32), these developmental restructurizations are moulded by and adaptive to the processes inherent in the organism; the organization of experience in the individual ego; and the social organization of family, class, community, and nation.

Investigators of developmental restructuring also report that deficiencies in living-through experiences essential for a stage, lead to developmental abnormalities. Deficiencies arise when the external environment is actually deficient in providing essential experiences; when the external environment is noxious; and when the internal milieu is markedly disrupted by endogenous conflicts. Clinical observations on deficiencies of each type, at various developmental stages, and on their sequelae have been published.

External deprivations occur with parental rejection (Mahler and Gosliner, 1955, pp. 200-201; Spitz, 1951) or abandonment (Spitz, 1951); parental illness of mind or body (Greenacre, 1952b; Keiser, 1962; Lipin, 1960; Mahler and Gosliner, 1955, pp. 200-1; Niederland, 1959; Winnicott, 1961); and social upheavals. Deficiencies of this type lead to psychopathology such as

anaclitic depression (Spitz, 1947), marasmus (Spitz, 1951), identification disturbances (Glover, 1933; Greenacre, 1953; Mahler and Gosliner, 1955), and diverse ego-superego defects (Greenacre, 1952a, 1953). Incidentally, an environment adequate for the discharge of maturational drive-representatives at one developmental stage may be deficient at another (Coleman, Kris, Provence, 1953; Jacobson, 1954; Mahler and Gosliner, 1955, p. 200).

Chronically noxious external environments accompany situations such as parental psychosis or psychopathy, wherein the child is utilized by the parents as object for conscious or unconscious acting out of primitive sexual-aggressive impulses (Greenacre, 1952a; Lipin, 1960; Spitz, 1951; Winnicott, 1961). Such atypical environments provide a massive dose of experiences that are pathogenic insofar as percepts and representations of them severely disorganize functioning and maturing (Lipin, 1960). Greenacre points out that:

'... It is ... the existence of continuous traumatic conditions or the recurrence of severe trauma which produces effects of sufficient magnitude to dislocate the regular development of the libidinal phases and consequently the integrity of the emerging ego.' (Greenacre, 1953, p. 90).

When deviations from the average expectable environment are substantially noxious and chronic, the danger to maturation has exogenous and endogenous components. The external danger comprises the atypical stimuli imposed from without. They evoke atypical mental states, dissonant with and disorganizing to normal states. Defences against this exogenous component often aim at minimizing interpersonal interactions by decathexis of object ties (Lipin, 1960). The internal danger comprises those maturational drive-representatives endogenously impelled, despite the pathogenic environment, towards essential-experience triggering of latent-capacity actualizations. But living-through atypical essential experiences concomitantly establishes self and non-self representations that engender distorted structured functioning. Defences against this endogenous component often aim at inhibiting those maturational drive-representatives that in the atypical environment do not propagate normal and constructive developments but, instead, abnormal and destructive ones. To the extent that these defences preserve a modicum of organizational and developmental integrity, they achieve an adaptation to the noxious

environment (Hartmann, 1957, p. 35). But their very success extends essential-experience deficiencies. Deficiencies inherent in chronically noxious environments and deficiencies arising from defences against such pernicious situations lead to characteristic psychopathology such as: coma in the newborn (Spitz, 1951); three months' colic (Spitz, 1951); infantile neurodermatitis (Spitz, 1951); hypermotility (Spitz, 1951); fecal play (Spitz, 1951); aggressive hyperthymic tendencies (Spitz, 1951); fetishism (Bak, 1953; Greenacre, 1953); disorders of speaking, learning and abstract thinking (Keiser, 1962; Lipin, 1960); fugue-like states (Lipin, 1960); and 'unusually severe neuroses and "borderline" conditions' (Greenacre, 1952b, p. 294).

Acutely noxious situations that produce acute 'traumatic experiences', impose a sudden, short-lived, 'penetrating' stress in contrast to a pervasive, chronic, 'grinding' stress. Acute traumata comprise experiences such as participating in or witnessing 'some particularly mutilating event' (Greenacre, 1953, p. 93), especially during the earliest years. Acute traumata form a heterogeneous group, with complexly varying vicissitudes of maturational and structural drive-representatives. This group does not lend itself to overall generalizations other than that a traumatic event actually lived-through seems to be registered differently and effects instinctual drive vicissitudes differently than does a phantasied event never actually experienced.

Disorganization of structured functioning by substantial endogenously rooted conflict occurs when disruptive structural drive-representatives in conjunction with grossly deficient ego functioning so decompensate mental operations that primitive defences such as projection, denial, introjection and splitting are evoked (Freud, 1920; Glover, 1933; Winnicott, 1960). These defences, favouring autistic type representations, so impair formation of reality-oriented representations that an external environment actually supportive is represented and reacted to as if it were deficient or noxious. Distortions of this type lead to essential-experience deficiencies and to sequelæ thereof.

The formation of clinically detectable developmental abnormalities within situations of specific essential-experience deficiencies may be described in metapsychological terms as follows. If essential experiences are not lived-through, regardless of cause, percepts and representations indispensable

for discharge of related maturational drive-representatives are not available. Consequently, biological processes dependent on such mental elements do not operate properly; their discharge is impaired or blocked; and latent impulses and capacities are not adequately actualized. Drive tension of the blocked maturational drive-representatives mounts as drive-energy generation continues. Homeostatic and constancy-principle tension-regulating processes are activated. Resultant defences progressively modify by counter-cathexes and displacements the normal discharge patterns and discharge thresholds of maturational drive-representatives. Gradually displacement patterns evolve that are dischargeable under the deficient conditions. This defence-adaptation to deficient circumstances and to related drive-discharge blockage is a normal process. But the atypical structured functioning constructed, although normal for the abnormal circumstances, is abnormal for normal circumstances. It is a stress structure; adaptive and defensive by virtue of a profound intrasystemic reorganization wherein instinctual drive representatives subserving tension regulation discharge to inhibit and distort instinctual drive representatives subserving maturation. Stress structure supports survival by replacing the externally oriented stress, associated with essential-experience deficiency, with this internalized intrasystemic stress.

Stress structure is often characterized clinically by unique functioning especially elaborated to compensate for the functional stunting resulting from essential-experience deficiencies. Generally, restitutive developments appear such as: compensatory hypertrophy of phase-appropriate functions to the point of precocity; compensatory activation of regressive functions; and compensatory evocation of 'unusual' functions not usually developed under normal conditions. The specific effects on structured functioning of interactions between: (a) both abnormal and normal essential-experience supplies, and (b) maturational drive-representatives, are described by various authors, including the following:

Bak: 'In the development of fetishism we will emphasize the following points:

Weakness of the ego structure that may be inherent, or may come about secondarily through physiological dysfunctions or through disturbances in the mother-child relationship that threaten survival. This may account for the inordinate separation anxiety that results in increased clinging to the mother totally, or to a substitute part of her as a

pars pro toto, leaving behind erotization of the hands and predilection for touching.' (1953, p. 286).

Keiser: 'The psychotic or borderline mother who blandly exhibits her nakedness to her son throughout his life to maturity undoubtedly imposes upon him the need to deny what he had seen and reinforces the operation of an archaic mechanism of denial. This in turn fosters the fantasy of fusion with her. The failure to incorporate, to introject, and to identify with the mother damages the ego functions of speech and thought processes as they involve abstract thinking.' (1962, p. 71).

Kris: 'The adaptive function of defence in general has been stressed, and the assumption has been made that the prospectively favorable development of autonomous ego functions is closely related not to the absence but to an optimal distance from conflict.' (1950, p. 28).

Hartmann: 'Our task is to investigate how mental conflict and "peaceful" internal development mutually facilitate and hamper each other. We must, likewise, study the interplay between conflict and that aspect of development with which we are familiar mostly from its relations to the external world. Thus, to take a simple example, learning to walk upright combines constitution, maturation of the apparatus, and learning processes, with those libidinal processes, identifications, . . . instinctual drive and environmental factors which may lead to conflicts and to disturbances of function. None of these processes alone can explain this important step in development.' (1937, p. 11).

The tension-regulating defensive functions central to stress structure become increasingly amalgamated into structured functioning if essential-experience deficiencies persist. But such structuralized functions remain adaptive and stable only so long as sustained deficiency circumstances persistently prevent maturational drive-pattern discharge. A change to non-deficient circumstances renders these structuralized functions misadaptive and unstable. Such a change may occur during childhood and does occur in adulthood. The erstwhile child with immature ego, living in the deficient or noxious family environment, becomes the adult with stronger ego, living in a community, neither deficient nor noxious. When essential experiences become newly available, they persistently excite (Freud, 1900, pp. 582-5) pertinent maturational drive-representatives whose discharge was blocked by deficiency circumstances and is blocked by anachronistic structuralized defences. Such sustained stimulation of blocked, normal-pattern maturational drive-representatives disturbs utilization of adaptive-defensive distorted patterns for discharge of endogenously

generated maturational drive-energy and thereby increases drive tension. Tension regulators are stimulated. Under conditions of the new, non-deficient circumstances, they inhibit the structuralized defences that are now misadaptive, and facilitate utilization of normal-pattern maturational drive-representatives for discharge of the mounting tension. In the prior stress, precipitated by deficiency blockage of newly arising maturational drive-representatives, tension regulators pressed to restructure normal discharge-patterns into distorted displacement-patterns. In the current stress, precipitated by structuralized blockage of newly excited normal-pattern maturational drive-representatives, tension regulators press to restructure distorted displacement-patterns into normal discharge-patterns. With this reversal of regulator activity, utilization of available essential experiences for discharge of normal-pattern maturational drive-representatives is progressively enhanced, whereas opposition by structuralized defences is progressively weakened.

The disagreeable subjective experience arising from the conflict between these newly stimulated impulses and the opposing defensive impulses is a replica of the prototype disagreeable experience, that arose long ago from the conflict between the same impulses, newly appearing according to biological schedule, and the frustrating deficiency circumstances. Such replicas appear clinically as repetition compulsion phenomena. The activity producing them as it presses for essential experiences, which when lived-through will stimulate reorganization of structure functioning along more normal lines, appears clinically as repetition compulsion activity.

V. Repetition Compulsion and Structured Functioning

Stress structure, as a specific type of psychopathology caused by essential-experience deficiency, is characterized metapsychologically by:

- (1) Stress due to discharge-blockage of biological processes subserving maturation.
- (2) Stress due to chronic stimulation of biological tension regulators and to their sustained discharge upon normal maturational drive-patterns in the service of distorting these patterns sufficiently and persistently for them to provide discharge of endogenously generated, maturational drive-energy.
- (3) Stress due to functional defects that arise

from discharge via distorted maturational drive-patterns and from non-actualization, because of normal-pattern blockage, of crucial impulses and capacities.

(4) Stress due to persistent residual excitability of normal maturational drive-patterns. This residual pattern-excitability, impervious to distortions by pressing biological tension regulators and appearing clinically as repetition compulsion activity, is geared to the internal reality of developmental stunting. Therefore, it is in conflict with mental activities geared to the external reality of object relationships.

These psychopathological features indicate that maturational drive-representatives are important determinants of mental phenomena not only during the normal developmental stages of roughly the first two decades of life, but also whenever stress structure exists. Maturational drive-activity that is associated with stress structure becomes especially pronounced and detectable at times when changed circumstances provide new possibilities for living-through new essential experiences. Such circumstances apparently stimulate the residual excitability of normal maturational drive-patterns despite the powerful counteracting and displacing activity energized by the biological tension regulators. This manifestation of the innate tendency of maturational drive-patterns to react in a specific, 'normal' manner to stimuli, is perhaps a derivative of the biological process of tropism. The normal-pattern unconscious id impulses that are newly stimulated and activated, persistently press, independently of pleasure-unpleasure considerations, to cathect and precipitate new essential experiences, which provide conditions for normal-pattern discharge and for attendant actualizations. The intensity of such maturational drive-pressure tends to reflect the extent of: (a) existent stress structure; (b) newly available and utilizable essential experiences; (c) residual excitability of normal maturational drive-patterns; and (d) current maturational drive-energy generation.

When stress structure is substantial and repetition compulsion activity is correspondingly intense, it is likely that all mental functioning and mental elements are co-determined in varying proportions by the interactions of unconscious maturational and structural drive-representatives. The outcome of such interactions depends on many complex factors, including (a) the rigidity of structuralized counteracting and displacing ego functions;

(b) the form and function of superego ideals and prohibitions; and (c) the intensity of unpleasure arising from the current misadaptations and deficiencies of stress structure in relation to current id, ego, and superego needs. Because the activity of stress structure is determined partly by maturational drive-representatives, it is possible to detect repetition compulsion activity determinants in many analytically observed findings of people afflicted with stress structure. In such individuals, for example: affects including anxiety often are replica fragments as well as 'reactions' or 'signals'; actions are often directed unconsciously to *relive* unremembered, unpleasurable experiential replicas as well as to *act out* unconscious impulses that provide pleasure or avoid unpleasure; and transference phenomena often arise from unconscious drives to live-through previously unavailable or unutilizable essential experiences as well as from unconscious 'infantile wishes'.

Moreover, such individuals frequently experience, as do infants, children, and adolescents, consequences of intense conflicts between maturational drive-representatives, operating beyond the pleasure-unpleasure principle, and structural drive-representatives, operating within the pleasure-unpleasure principle. Such intrasystemic id conflicts may produce as severe regressions and decompensations as do some id-ego, id-superego, and ego-superego conflicts (Jacobson, 1953, pp. 62-65).

The following clinical fragment dealing with an experiential replica produced by repetition compulsion activity, illustrates some operational features of an underlying specific maturational drive-determinant, and some interactions between it and an underlying specific structural drive-determinant:

The patient whose usurpation of his superintendent's and painter's roles was described previously, was impelled unconsciously to such action by detectable unconscious impulses belonging to both categories of drive-representatives. Although unconscious id impulses of both types reinforced each other in the precipitation of the experience, those of each category had a different over-all aim to be attained through the action. Therefore, those of each type pressed to elaborate the experience somewhat differently. The maturational drive-determinants were aimed at attaining biologically 'proper' structured functioning. They catapulted him into the unpleasurable experience of unconsciously re-

living early-life stresses related to interactions with his borderline or possibly psychotic mother. The structural drive-determinants were aimed at attaining biologically 'optimal' operation by means of existent structured functioning. They propelled him into the pleasurable experience of unconsciously acting out unconscious wishes characteristic of his distorted structured functioning.

One specific maturational drive-determinant that was stimulated to normal-pattern activity by his current circumstances arose from those biological processes that require for their discharge his living-through the essential experience of belonging to those around him; being related to by them as a valued person; and acquiring from them commensurate rights and responsibilities. This essential experience regularly provided by the average expectable early-life environment was not provided by his deficient early-life environment.

This essential experience of belonging, when cathected and precipitated by the maturational drive-representative at the usual developmental stage early in life, permits this maturational drive-representative to discharge and to actualize certain object-related impulses and capacities. These existed previously only as biologically organized potentialities without operational existence or mental representation. Their actualization makes possible normal hierarchic development of structured functioning. One feature of the higher level organization is its structuralized capacity to maintain normal drive-tension limits of the very same maturational drive-representative that by discharging made possible the developmental restructuring.

In the case of this patient, however, the belonging-experience was never lived-through properly and adequately. When cathexis of this essential experience by the maturational drive-representative was stimulated anew by the current circumstances in adulthood, the experience could not be precipitated as it would have been in early life, because unconscious structuralized, defensive counteracting and displacing functions blocked discharge via the normal pattern that would have provided it. These defences forced the newly stimulated maturational drive-energy to discharge via distorted patterns. Such patterns did not precipitate the belonging experience. Instead they produced an experience of defensive estrangement and detachment from the very same individuals towards whom he unconsciously was stimulated to belong. This

experience did not actualize the impulses and capacities required for restructuring along more normal lines.

Notwithstanding this failure to discharge normal patterns and to actualize new capacities, the cathexis of the belonging-experience by the normal-pattern maturational drive-representative unconsciously precipitated an experience which brought into perception (a) the activity of unconscious structuralized defences and (b) the misadaptation of these functions to current circumstances. On perceiving this, diverse ego functions, stimulated by living-through the estrangement experience, were mobilized to facilitate maturational drive-discharge via normal patterns instead of via displacement patterns. Such blending of ego and id pressures initiated processes which eventually made possible (a) precipitation of a belonging-experience; (b) discharge of normal-pattern maturational drive-representatives; (c) actualization of new impulses and capacities; and (d) developmental restructuring of structured functioning.

A specific structural drive-determinant of his usurpation arose from biological processes, organized on a higher biological level than those just considered, that discharged their endogenously generated drive-energy by the unconscious acting-out of unconscious sadistic impulses to torture his parents. One method employed was unconsciously to demean various individuals, who like the superintendent and painter were unconsciously associated with his parents. Another method was unconsciously to demean all extensions of his parents, including himself. When such impulses to hurt his parents became conscious, they evoked pleasurable affects.

That these two drive-representatives with different aim and regulation were occasionally in intense conflict which further disrupted, fragmented, and split the existent impaired structured functioning, was noted but will not be described.

When re-experiencing a replica in current non-deficient circumstances, two new processes are set in motion. Firstly, as reliving occurs, the individual contemporaneously experiences and represents newly actualized fragments of impulses and capacities still predominantly latent. Secondly, by living-through the replica and experiencing the new impulses and capacities, he perceives, represents, and integrates, for the first time, the relationship between early-life protective reactions generated by defensive

countercathexes and displacements, and current debilitative reactions generated by the identical structuralized defences. New representations of budding new impulses and capacities, and new representations of both old and current determinants of his distorted functioning, make it possible for the individual to promote deactivation of anachronistic defences, and reactivation of normal impulses subserving maturation. In the restructuring that ensues, structural-type memory registrations are converted into representation-type memory traces.

Summary

This paper reports on a reinvestigation of the clinical phenomena first described by Sigmund Freud in 1919 as the repetition compulsion.

Freud's observational data on the phenomenon and his inferences about the unconscious activity producing it are reviewed.

Findings are presented supporting the view that the phenomenon exists and is clinically detectable. Observations are described outlining some features of the unconscious activity that produces recurrent experiential replicas of stressful past experiences whose essentials are unrecalable. Three patterns by which this unconscious activity constructs such replicas are considered.

Characteristics of the unconscious activity are examined to determine its source. Freud's contention, opposed by some, that it is an instinctual drive representative, is supported by this study.

Investigation of the activity's unique features, that differentiate it clinically from all the drive representatives described before 1919, leads to the delineation of two categories of instinctual drive representatives. Drive representatives of one category are aligned with processes that produce, as accurately as circumstances permit, progressive maturational unfolding of structured functioning, according to an innate genetic blueprint and timetable, until adult organization materializes. They are classified as maturational

drive-representatives. Drive-representatives of the other category are aligned with processes that maintain integrity of phase-specific structured functioning as effectively as circumstances permit. They are classified as structural drive-representatives. Repetition compulsion activity is inferred to be a maturational drive-representative.

Characteristics of processes bringing about mental development and conditions for optimal operation of such processes are studied to infer the operational features and discharge patterns of maturational drive-representatives. Certain experiences appear to be essential for the proper discharge of these representatives and for the actualization of impulses and capacities that make development possible.

Deficiencies of such essential experiences lead to discharge-blockage of normal maturational drive-patterns and to complex distortions of structured functioning. The resultant defensive-adaptive stress structure is based on a profound intrasystemic reorganization wherein instinctual drive representatives subserving tension regulation discharge to inhibit and distort instinctual drive-representatives subserving maturation. One clinical manifestation of this intrasystemic id conflict is repetition compulsion activity.

When stress structure is substantial and repetition compulsion activity is correspondingly intense, it is likely that all mental functioning and mental elements are co-determined in varying proportions by the interaction of unconscious maturational and structural drive-representatives.

Experiencing (a) repetition compulsion activity's actualization of new impulses and capacities, and (b) concomitant activation of anachronistic structuralized defences, brings into perception a network of impulses that was previously unconscious. Such perception makes it possible for the ego's working-through processes to support and reinforce the thrust of normal maturational drive-patterns to restructure distorted structured functioning along more normal lines.

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IMPULSIVE SEXUALITY: SOME CLINICAL AND THEORETICAL OBSERVATIONS¹

By

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The observations which will be described and discussed in this paper were those made by the author while treating patients who entered therapy primarily with symptoms of depression and intermittent episodes of sexually impulsive behaviour. In men, the sexuality consisted of promiscuous and perverse relationships with actual prostitutes or with other women of loose behavioural standards. The most common of these perverse activities were exhibitionism, paedophilia, voyeurism, fellatio, and cunnilingus; the promiscuous behaviour with the sexual partner consisted generally of mutual bodily or genital manipulation, fellatio, cunnilingus or both. While in some the perversity assumed a polymorphous quality, in others one particular perversion seemed most prominent. Continued observation of the latter, however, eventually indicated that the individual concomitantly indulged in other perverse acts, or at least had done so in the past. These observations are similar to those previously reported by Greenacre (1955). In women, the sexual behaviour consisted in promiscuity with a great variety of men. Their sexual activities included bodily contact, caressing, and kissing; coitus was rare and provoked reactions of disgust. Thus, the genital form of sexual expression was absent from the relationships. What did transpire, it is suggested, was actually a screen for a more basic desire, viz.: the need to be closely fused with the mother in a symbiotic relationship. In terms of such a relationship, the perversions represent, as Freud (1905) in his earliest paper on this subject indicated, a perpetuation of infantile sexual activity which interferes with adult genitality. Characteristic of such perversions is marked orality.

The main intent of this communication will be to develop, on the basis of clinical observations

and theoretical construction, the following hypothesis: sexually impulsive behaviour, precipitated by imagined or real object loss, is a desperate restitutive measure to re-establish a symbiotic relationship upon which ego integration depends.

Reaction of the Sexually Impulsive Patient to Object Loss

Continuing contact with such patients has repeatedly demonstrated that they manifest extreme sensitivity to imagined or actual separation or loss of a currently needed person. Such an event is perceived as a great danger and precipitates marked narcissistic anguish, agitation, depression, and sexually impulsive behaviour. Strongly experienced rage and/or panic, behavioural patterns comparable to the 'organismic distress' of infants described by Mahler (1952), are typical reactions. Any feelings of emotional repudiation by a significant object, even an experience which would certainly be of relatively minimal importance to most people, sets into motion a desperate and frantic search for a substitute object who will respond with feelings (even though illusory in nature) which they can interpret as acceptance and love. Such a response serves to allay the psychic feelings of helplessness and aloneness, and the frequently accompanying somatic symptoms of rapid heart pounding, laboured breathing, and increased respiration. In pursuit of such an object, these patients become overwhelmed by restlessness which makes it impossible for them to carry out their daily responsibilities. They act on impulse as if their judgement is entirely suspended. They tend to wander the streets until they eventually end up in red-light districts, burlesque or peep shows, brothels or taverns of ill-repute, seeking and searching for opportunities for instinctual gratification.

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To be liked by or involved with someone, then, is not only reassuring, but very necessary to their social and psychological equanimity. Any inter-personal conflict with a needed object mobilizes a masochistic response. So important is this to them, that such patients prefer self-sacrifice or jeopardy of self-interest, rather than to incur the dislike of the object they deem to be essential. They convey an insatiable yearning to merge with the object by bodily contact, and thus symbolically to be like the desired objects themselves. They display an avidity for object addiction. One patient after one year of analysis expressed his feelings as follows:

'I feel like a cork drifting in the water of a stormy sea, and being tossed around aimlessly. It should be ludicrous to ask if you'll get rid of me. Yet I react the same way with my wife. I want her to tell me she'll stick with me. Even though she reassures me that she will, I still have the feeling that she will leave me. Her assurances do not *shackle* her to me, and the same feeling is true of you.'

The panic stems not only from the loss of the needed object but, in addition, there is a basic anxiety which stems from the ego's helplessness in trying to cope with the intense sexual and aggressive impulses—a situation which is felt, by some (Greenacre, 1941; Geleerd, 1958), to be pathognomonic of the borderline case. In some instances such impulses may be acted out against maternal surrogates. The rage thereby assumes a symbolic function, as when it refers to deprivations or when it is used as a means of gaining control over a figure vested with omnipotence (Weiss and Blatt, 1961).

While the character, nature, and specificity of object loss are variable, a frequent precipitant, in male patients, of these feelings is the imminent arrival of a new baby in the family. The reaction may be limited to the first-born child, but it is not unusual to observe sexually impulsive behaviour to the second, or even at the impending birth of every child. And it is certainly not unusual to discover that patients who heretofore had reached some stage of stability, in spite of earlier tendencies to impulsivity, will suddenly undergo a stormy emotional upheaval in such a situation, and present clinically 'all of the manifestations which were described previously. Similar reactions have been observed by others (Christoffel, 1956; Grotjahn, 1948).

In contrast, sexual impulsivity subsides in female patients when they become pregnant. During gestation and the post-partum period,

when the infant is anacritically dependent upon them, such women do not experience promiscuous urges. When, however, the infantile need of them lessens, they experience feelings of depression, and with it the need to engage in sexually impulsive behaviour. In the course of such an emotional upheaval, such corollary situations as disappointments, experiences of personal failures or failures by those with whom there is an identification (as with a favoured team), assume a psychic representation of object loss capable of mobilizing feelings of great despair, unworthiness, and an intensification of the sexual urges.

As can be noted from the examples already given, and from the following pertinent self-observation of one of these patients, the sexual impulsivity and depression cannot be separated; they are both parts of the same pattern.

'If something happens which separates me from a close friend, my reaction is that of an emotional let down, and with it, I feel tremendously depressed. I get upset when someone close to me departs. Last year, when my wife was away in the hospital a great deal of the time, I'd get out every night after leaving the office and go to bars, and most of the time, I'd end up in terrible places with terrible women.'

Thus, it has been suggested (Greenson, 1957) that impulse disorders should be termed 'impulsive-depressives' (p. 138) to emphasize this relationship. It further should be noted that both patterns belong to the pregenital oral states of development (Abraham, 1924; Fenichel, 1945) and are characterized by marked narcissism and low frustration tolerance. The cyclical nature of the disorder is stated by one patient who concluded:

'It seems as if this week I can look at something which is sexually provocative, get some enjoyment out of it, but when it is over, I can forget about it. I have no need to go out and indulge in a lewd act. I was trying to recognize that I have periods of depression and periods of well-being. The only explanation for the way I am now is that there is a cycle and with this well-being the neurotic feelings are overcome and I don't have these urges.'

The Search to Alleviate the Loss

When the reactions which were described above occur, there is need to overcome the loss by immediately replacing it by a substitute that is capable and willing to respond to the intense pregenital needs which the loss mobilizes. For

the male the object must be seductive and permissive, and will be particularly attractive if she is endowed with prominent breasts. Freud (1912) stated that she represents the degraded object. Lampl-de Groot (1946) characterized such an object as follows: 'The degraded sexual partner . . . is the heiress to the image of the mother in the preoedipal phase . . . he can mistreat her, can force her to satisfy all his needs and desires, even perverse ones, and can compel her to attend to his wants as he wished his mother to do when he was a little boy.' The prostitute, or anyone in a similar role, epitomizes such a pregenital object, and the pregenital needs of the male patient manifest themselves in perverse behaviour. Freud (1905) observed that such pregenital tendencies are not only the predispositions of the infantile, but are also innate in 'the average uncultivated woman', because he ultimately went on to say: 'Prostitutes exploit the same polymorphous, that is, infantile disposition, for the purpose of their profession.' The prostitute in her own way acts out similar needs with her clients (Lichtenstein, 1961; Hollender, 1961). In their sexual union each becomes a reciprocal component of a needed symbiotic relationship. The availability and willingness of the object to respond is reassuring and allays the tension. Hence, such patients feel content and gratified in going to bars, and to other places frequented by prostitutes or promiscuous women. Their contentment stems from the assurance that if the need becomes too great, there are at their disposal objects ready and willing to respond to their pregenital needs. Desire for genital penetration is rare, and if attempted is anticlimactic, usually unsuccessful, and frequently mobilizes feelings of disgust.

The female patient, whenever she is overwhelmed by feelings of loss or aloneness, will impulsively abandon her home, her husband, and her children and begin to frequent numerous parties or bars in search of any object, irrespective of sexual identity or at times even of age, with whom she will engage in heavy petting, bodily manipulation, and kissing. Through such bodily contacts the need to reestablish the disturbed symbiosis is fulfilled and in the process the pregenital needs for cuddling, caressing, and touching, are gratified. This is so erotically experienced that an orgasmic climax is achieved.

Phallic-vaginal contact is resisted since such relations provoke revulsion and disgust.

The whole relationship to such an object corresponds to the infantile state. If the infant feels that his mother is around and available to satisfy his needs whenever they arise, he feels content and confident (Benedek, 1938).² When such an atmosphere is repeated in the transference sexual impulsivity and reactions to loss are reduced.

Disturbed Differentiation Between Self and Object—Genetic Antecedents and Subsequent Ego Impairment

The anamnesis in the majority of these patients revealed that their fathers were weak, passive, ineffectual, indifferent, detached, or were totally absent during the patient's development. The mothers were rejective, ambivalent, seductive, domineering, over-protective, and controlling. The mother, on the basis of numerous fantasies which emerged in the course of therapy, is symbolically perceived in the image of a spider or octopus. With the former (spider) the victim becomes enmeshed and adherent to the web, following which the spider approaches and sucks out all the fluid from the victim who is, thereby, totally destroyed. One patient likened his mother to an octopus which grasps its victim with its tentacles and crushes it. He described it as an 'embrace of death'. The threatening image of the mother is unconsciously determined. Oral frustration not only contributes to a fixation of this need but also the associated aim becomes sadistically fixated. The orally sadistic inclinations are deflected from the self onto the object, who thus becomes perceived as potentially destructive. The mother is perceived as an object who can enmesh the subject to herself and then destroy it. A dilemma develops in relations towards the object. On the one hand, any separation or loss of the object is perceived as a severe threat; yet there is great anxiety whenever the object becomes unreservedly responsive, since such a situation provokes great fear of total dissolution of the self by the object. Interest in the object will suddenly cease, and the relationship will be disrupted. The search for a new object will then be resumed, and the cycle is again repeated. One patient who had great difficulty in elucidating

² Benedek suggested the formulation that confidence develops when the 'borders between ego and "you" are not yet marked definitely'. This would correspond

to the period when differentiation between self and object begins.

his thoughts verbally, and who therefore utilized symbolic examples to facilitate his communications, expressed himself about the nature of his relationships with objects as follows: 'What I want with her (referring to a current female attachment) is this,' and then demonstrated the idea which he tried to convey by lifting up both his hands with fingers interlocked, 'but I don't want this', and illustrated this by waving one of his arms up and down in reference to the wall which was adjacent to the couch. 'This frightens me, and when I feel this going on I lose interest and get out.' The wall represents an indistinguishable unity in which there is total fusion and complete loss of self-identity. During periods of serenity, he would stroke the wall gently; during periods of rage, he would bang the wall painfully with his fist. On another occasion he described his desire as follows: 'What I want with her is this', and illustrated by pressing the index finger vigorously against the thumb. In most instances it became apparent that an early disturbance in the mother-child relationship had existed and fostered a poor differentiation between them, thus perpetuating a symbiotic attachment of the child to the mother. The symbiotic mode of interpersonal relations becomes fixated in the child, and will characterize his future transactional operations with significant objects. The integrative stability of such individuals is vulnerable and the loss of a needful object is subjectively experienced as a marked suffering and severe separation anxiety.

As an example of the metapsychological constructs so far developed, the following short dream of a female patient is illustrative. She was a social worker who, though successful in her work in a residential school for neglected children, suffered from frightening fantasies of suicide, feelings of dread and panic, and marked apprehension that her breathing might stop. She had a distrust of people, and was constantly in terror lest she would be abandoned and deserted. She could not bear being alone; she could not eat unless someone was sitting with her. She panicked whenever she was separated from her cat, her boy friend, or from her landlady. At the end of the second session she reported this dream: 'I was in a group of women at school and a string which connected

me with them broke. I woke and was very frightened. My dreams always come true. The next day a girl was dismissed from my cottage.'

The string represents the symbiotic bond with the needed object upon which her stability and integration depends, provided it remains unbroken. Disruption or separation from the object produces marked panic, and cardiac or respiratory psychosomatic consequences. The dismissed girl refers to her own constant dread of separation from a needed object.³

In response to the subjective anguish of aloneness and void, there is a desperate need and compulsion to establish the disrupted symbiotic bond with another object, an aim that precipitates impulsive sexuality. The latter is associated with a restitutional attempt to re-establish what Mahler (1952) describes as a 'symbiotic parasitic fusion' with the desired object. Otherwise disintegrative phenomena such as feelings of estrangement, depersonalization, transitory delusions and hallucinations, strong suicidal potential, and a resurgence of the primary process become clinically apparent. These observations seem to correspond with Glover's (1933) conception that the perversions (as well as drug addictions) are 'the negative of the psychoses'. One patient faced with imminent separation described his reactions as follows:

'I went to bed and couldn't sleep. I suddenly felt overwhelmed and began to consider suicide seriously. All of a sudden I had a tremendous feeling of loneliness. Suddenly, I got the idea to get out of bed and go on the prowl to look for a prostitute.'

Accordingly, in the middle of the night he drove his car to a Negro area where he was approached and solicited by a coloured prostitute. 'I struggled with myself whether or not to ask her into the car, but there was a tremendous need to counteract the intense loneliness. Once I made up my mind, I refused to rationalize my actions.' After the woman got in the car, she performed fellatio on him.

In analysis the transference assumes a symbiotic quality and the inter-identification manifests itself in a reversal of roles between the patient and the analyst, who is perceived as the feeding and maternal object. At times the roles seem to be reversed, so that the analyst becomes the needful infant, and the patient the gratifying

³ Another patient fantasied himself to be like an unborn child who is attached by his umbilical cord to those who are important to him. On another occasion, he saw himself as a 'fish out of water—with all the

gasping and heartbreaking. Perhaps I need to be surrounded by water—like in the womb.' The patient was subject to intermittent asthma-like attacks and constant dread of a heart attack and death.

object. The reversibility of roles is epitomized by fellatio fantasies in which at times the analyst is the active participant; at other times, the patient. Frequently the roles are simultaneously fulfilled in '69' fantasies. These inclinations are acted out with women who perform fellatio on them; this in turn is followed by cunnilingus or, as in the fantasies, both partners will act out their roles in the '69' position. Thus, via such oral incorporative gratifications, a primitive type of identification is achieved by a refusal of self and object images (Jacobson, 1954). Reversibility of roles is especially notable in the interpersonal relationships between homosexuals.

These observations will be illustrated by a description of two cases observed in analysis. The descriptions of the early phases of the analysis will be limited to such details as will both demonstrate the hypothesis suggested in this communication and convey the overall character of the transference.

Clinical Illustrations

(a). The patient was a 30-year-old man, the father of three young sons, who came to analysis when it became apparent that his own emotional problems contributed to an emotional disturbance of his middle child. From the moment of his birth, the child was an object of the patient's envy, hatred, and violence. At one time he described with veiled glee how he gave the night feeding to the infant. He arranged the bottle in such a manner that when the baby was about to put the nipple in his mouth, the bottle would drop away. He repeated this arrangement until the child became frantic. On other occasions he purposely tried to create the feeling in the child that he was falling while eating, by dropping the child but not allowing him to fall completely. In addition to a chronically morbid fear of disease and death, episodes of depression and lack of confidence in himself, he constantly felt that he would be pushed out by his business colleagues and his wife whom, as a consequence, he attacked physically from time to time. After considerable hesitation he finally revealed his greatest concern: periodic episodes of perverse and licentious behaviour with women. The anti-social behaviour became most marked following his marriage when he began to make anonymous telephone calls to women and engage them in lascivious conversation. Later he began to embark on voyeurism, making indecent sexual propositions to adolescent girls, molesting little girls and frequenting taverns of

ill repute where he would indulge in bodily and genital manipulations with strippers or become involved with some promiscuous women with whom he engaged in fellatio, cunnilingus, or both. Frequently he cruised in his car or walked through the park to watch young couples petting or necking. Whenever he saw a woman with a low neckline dress exposing her bosom, he stopped to stare. Often he followed such women to the doors of their homes, in the hope that one of them would invite him to have sexual contact with her.

His own mother died as he was being born and his father deserted soon thereafter. He was then adopted by a wealthy childless couple. It was not until two years prior to the analysis that he became aware of his adopted mother's chronic alcoholism. She was unusually concerned about his bowel movements so that whenever he was constipated or complained of the slightest stomach distress she gave him an enema. At first he resisted, but gradually began to experience considerable erotic satisfaction so that eventually, when he learned to masturbate, he gave himself enemas.

When he was a child, she told him frequently that she would not be around too long in this world. In his adolescence, both playfully wrestled on the floor. Often she was on top of him and he noted a 'wild ecstasy' on her face. His adopted father, an energetic man and capable of violence, became a cardiac invalid when the patient was 8 years old and was dead by the time the patient was 15. About this time he began to frequent houses of prostitution regularly, and to engage in homosexual activity consisting of mutual masturbation with his best friend. One year later, his mother remarried and he was sent to a military school. At this time he felt he was pushed out to get him out of the way.

In the analysis, he was constantly fearful and uncertain of his position. He frequently tested the analyst's reactions by coming late to the hours or by threats of abandoning the analysis, coupled with a hopeful expectation that he would be implored or begged to reconsider. Such actions by the analyst would prove to him that he was really wanted and that somebody really cared. There was marked clinging to and possessiveness of the analyst, and overt expression of hostility towards the analyst's other patients. He rebelled against the analyst's passivity and silence and he reacted with constant complaints, nagging, provocation, antagonism, demandingness, and sarcasm. He

experienced an ever-prevailing uneasiness and distrust about the analyst's intent and sincerity, and suspected that he would be ultimately hurt. He manifested a marked sensitivity to every conceivable mood which he felt the analyst was experiencing.

The slightest lack of interest, suggestive or imagined coolness, distancing or unenthusiasm led to anxiety. The way the analyst greeted him or said hello to him affected him. These perceptions, real or imagined, provoked great uneasiness since his observations were construed as preliminary evidence of an impending disruption in the relationship; he reacted with noticeable oral somatization (such as increased clearing of his throat, an intensification of his appetite, rhinitis, choking spells, asthma-like attacks) depression, and sexual impulsivity. Early in the analysis he made this observation:

'I notice I get very hungry when I'm here. It seems to be tied up with a general feeling of yearning, a feeling of wanting to merge with you, or to be like you. It's a feeling which is never satisfied. Always, there is the feeling you'll drop me if I do something which displeases you. I would like you to take me with you, take care of me all the time and love me. If something should happen to you, what would happen to me?'

A more microscopic examination of the transference is elucidated by focusing on his dreams and associations which are described in the order of their appearance.

The first dream demonstrates these projective perceptions; the analytic atmosphere is perceived as erotic and permissive; the analyst is conceived as someone who is sexually aggressive and stimulating; the analyst is symbolized in the guise of a seductive prostitute.

'I was sitting in the back row of a movie. A blonde woman came in and began to make sexual overtures. We left the movie together and somewhere in the movie she turned out to be my wife. Physically she didn't change, but she was a prostitute. I asked her when and how long this had been going on. She said it started after or just before we were married. I felt terrible about it.'

Associations: His wife is a brunette. She constantly encourages him about the analysis which she highly approves and in which she has a lot of faith. He has noted that at times some of the ideas the analyst expresses correspond a great deal with his wife's.

The following dreams convey the analytic

scene as being equivalent to a house of prostitution. Here, under the guise of a homosexual relationship, he expects to indulge with the analyst whose identity as an object is unclear. Gradually it becomes apparent that the object is motherly and his attention is particularly cathected to the breast or its equivalent which he wishes to suckle. Similar observations were made by Eidelberg (1956) in his work with homosexuals for whom the analyst represented the preoedipal mother. When the cathexis of his wish to the analyst mounts, this patient immediately defends himself by projection, a phenomenon instrumental to paranoid-like behaviour in the transference.

(1) 'I was in an old building which was strange to me. I was informed that the whole building was a house of prostitution and controlled by a syndicate. There was a lot of activity. People were running around. I was half-frightened and half-desirous of going into this myself. One of the receptionists seemed to be desirable. I think it was a doctor's office. I kissed her. She was very receptive. Then we were alone. She was blonde. She leaned on her desk, but nothing happened.'

'It was not clear in my mind whether she was a young man or woman. Then I was on an elevator, and could see into the rooms of the building.'

'In one, I could see two men sitting near the window. One was committing a homosexual act on the other who wore a bathrobe, and he was sitting cross-legged on the floor. His friend was lying beside him and holding the other man's genital underneath the bathrobe. He had just finished the act and in a matter-of-fact way spat out the semen on the floor beside him.'

Associations: When he was 15 he engaged in mutual masturbation with his best friend who is a blonde.

(2) 'A woman and I are in a room naked. We have intercourse in a standing position. She stood on her head, but even so her breasts seemed to be at a level with my face. The nipples were elongated so that they seemed to be a couple of inches long. They seemed to have an attraction to my mouth.'

Associations: In the past he and the woman in the dream (a switchboard operator in his office) used to engage in mutual masturbation secretly in the warehouse. The nipples were like nipples on baby bottles. From the position it would appear that her vagina was opposite his face, but this was not so in the dream. He often

tried desperately to persuade her to allow him to perform cunnilingus on her, but she refused; and then related another dream.

(3) 'I was in an office. A very beautiful woman walked in. She wore a very low-cut dress which was cut down to her breast. It seems she deliberately bent down so that one of her breasts was exposed in a tantalizing fashion.'

Associations: The woman was teasing. He wanted to touch the breast and put his mouth on it, but he couldn't because other people were about and were watching. The shape of the woman's breasts was odd. Instead of being round, they were long, slender, tubular and pointed. He then recalled that when he was 14 he had his first experience with a prostitute who had long tubular-shaped breasts—like bananas, which he has grown to dislike. She was motherly, tender, coaxing, and patient. He has never forgotten her.

'My going to her became a habit. She was more gentle and comforting than my mother was. Lying naked with her and having her handle my genital and kissing me all over my body, as she did, was comforting.'

It worried him now that he was confusing the banana-like breast with a penis and that if he kept talking as he had been, he would be attacked by the analyst.

(b). The second illustration is that of a 31-year-old married attorney, the father of two sons—4 and 2 years old respectively—who came to analysis because of sexual impulsivity which he feared would ultimately jeopardize him professionally if he were apprehended. The acting out, though previously prevalent, became more marked during and following his wife's pregnancies. In addition, he was subject to frequent episodes of depression and was prone to premature ejaculations. He was a thumbsucker until he was 7. Masturbation followed and continued. It was accompanied by fantasies of fondling or sucking a woman's breast. Also, at about 7 he put on the clothes of his sister, 6 years older than himself, and experienced erotic excitement. From then on he engaged in masturbation and intermittently in transvestitism. Both of these sexual activities were accentuated after his wife's pregnancies, but he did not experience full satisfaction from them. Following some sexual excitement (most typically aroused by seeing a woman in a tight-fitting sweater or wearing a low-neckline dress that revealed the cleavage of her breasts), increased responsibility, disappointment or failure in

himself, or by those with whom he would identify, he reacted by engaging in cycles of sexual acting out. These lasted from a few hours to several days. Preceding the actual acting out, he felt suddenly overwhelmed by depression, inability to carry on his work, restlessness and tension. He would interrupt his work and begin to wander in the streets. Both the acting out and his inner tension had a crescendo-like quality. He drifted to peep shows or to burlesque shows where he would masturbate. Usually, he ended up in taverns of ill repute frequented by prostitutes. He became excited by the licentious atmosphere he felt in these bars.

About four years prior to analysis, he met a particular prostitute whom he saw frequently. Whenever she saw him she expected him to join her. Both would go to a secluded booth where they would kiss and caress. He played with her exposed breasts while she manipulated his penis until he ejaculated. This was the essence of his sexual contacts, not only with her, but with other women.

The parental home was turbulent. The parents, early in his life, were frequently on the verge of divorce. He admired his father's intellectual and aesthetic qualities, but had no respect for him as a man. He felt his father was weak and passive, and that the mother, relatively, had greater strength. He often, nostalgically, referred to the closeness which existed between himself and her. He remembered pleasantly his long sieges of 'strep', sore throats when mother was constantly at his bedside caring for him, and the terror he experienced whenever he was separated from her.

When he was 8, the relationship with his mother changed. His older sister developed meningitis and was incapacitated for several years. He felt suddenly neglected. Mother began to drink and gradually became a severe alcoholic. Whenever he came home and discovered mother was away drinking, he reacted with marked anxiety. When she returned home drunk, she would rant and rave during the night, and he in turn was overwhelmed with such rage that he occasionally attacked her physically.

At times she brought home a male drinking companion, and this led him to suspect the nature of his mother's behaviour with these men. During her drunken periods he often saw her naked as she went to the bathroom. When mother was sober, he felt she was considerate, strict, forbidding, and moral; when intoxicated, she was permissive, sensuous, seductive, and

immoral. Actually his conception of his mother's characterological qualities was the prototype of his own behaviour. He considered himself to be a Dr Jekyll and Mr Hyde. The greater part of his time he was a respected member of his community and the legal profession in which he was a paragon of ethical honesty. Yet, part of his time, within the last few years, he was prone to impulsive indulgence in clandestine perversion and lewd behaviour.

Early in the analysis, the analytic setting was perceived as being equivalent to a house of prostitution. Thus, he opened one hour with the following observation:

'The thought struck me as I walked into the room, it was as if I were walking into a house of prostitution. This idea came to me in the way you said hello.'

On another occasion he made another observation: that the analyst is like a prostitute who shares her favours with many as long as she is paid. He also fantasied that coming to the analytic hours was like coming to be 'wet-nursed' by the analyst. He compared himself, in his purpose, to be like a 'politician who indulges in graft by sucking the public dry.' He observed that on the days he did not have an analytic hour he was more prone to be depressed and was more inclined to masturbate.

Early in the analysis it became evident that when the duration of his separation from the analysis was increased, not only did his depression and need to masturbate increase, but the urge to act out in the manner described became much more intense. This connexion assumed a symbiotic quality. The patient became a needful infant, the analyst a feeding and maternal object. As in the previous case, a more microscopic examination of the transference can be obtained by focusing on his dreams and associations which are described in the order of their appearance:

The first dream is self-explanatory:

'I had gone into some vice den and paid a man to allow me to sit with a woman in a booth. When I got there it was a man instead of a woman. He was sitting down and asking what form of masturbation I prefer.'

Associations: The amount of money he paid to the man in the dream corresponded with the analyst's fee. Hence the man in the booth must be the analyst.

A later dream:

'I was on my way to a room in a building to change my clothes. As I approached the room

I saw a lot of women there, and they were partially dressed. They were patients who were getting some kind of treatment. I did not enter, but stood outside—in the reception room—looking in. The nurse in charge saw me and made them leave, and she came out. She was coloured and her breasts were exposed. I began to talk to her and I started to fondle her breasts. We then went into the room and she suggested that we have intercourse. I was reluctant, but she placed my finger in her female organ and she created a sucking sensation with her organ like a person sucking his thumb. I was so stimulated that I wanted to have her right away.'

Associations: There were several beds in the room. In reflection, standing outside the room looking in corresponded with his sitting in the reception room near the analyst's door waiting to be called in. The coloured nurse, therefore, must be the analyst, a thought which occurred to him when he awoke from the dream.

Another dream of a similar nature came up a little later:

'It involved a coloured prostitute, and my recollection is that this was the same one I had intercourse with on a prior occasion in a dream. I was getting ready to have intercourse with this prostitute again, but my sister was also there, and she would be the first to have intercourse with the coloured woman. They went into the bathroom and I waited.'

Associations: Since the prostitute was connected with him and his sister, it would seem she stands for his mother. One can be with a prostitute only temporarily, depending on the amount she is paid. A similar situation prevails with the analyst, whose connexion with him will continue as long as he pays the analyst.

Independently he came to the conclusion that whatever improvement he had achieved could be attributed to the fact that since he perceived the analytic setting as a 'den of iniquity', and the analyst as a prostitute and as an object for satiation, all these elements had become substitutes for his former sources of satisfaction.

In other words, with the establishment of the transference to the analyst as a pre-oedipal maternal image, acting out outside the analysis is gradually reduced, the conflict becomes drawn into the analytic scene, and the struggle then revolves around the analysis of the transference.

Discussion

Impulse neuroses, Fenichel (1945) observed, are rooted in an early phase of development in

which striving for security and sexual satisfactions are not yet differentiated. Frustration mobilizes strong feelings of violence which must be relieved immediately through impulsive actions that serve as a defence against real or imagined danger. Earlier, Freud (1926), who had already considered this danger as economic, described it as an accumulation of stimulation which cannot be adequately eliminated except through the intercession of a mothering object. Experience eventually leads the child to the realization that the mother, through oral fulfilment, is an alleviator of the dangerously accumulated tension. Subsequently the danger becomes transposed from the original economic one, which is associated with marked feelings of helplessness, to the fear of losing the needed mothering object. Recognition of the needful object occurs about the period when differentiation between the self and object begins. It also corresponds with the beginning of confidence which develops provided that the relationship of the infant with the mother has been secure and gratifying (Benedek, 1938). The dreaded economic situation, precipitated by the threatened or actual loss of the object, mobilizes respiratory (crying) and motor (agitated thrashing) activities in order to attract outside help (Freud, 1926). Patients in this study manifested similar reactions. Many of them would develop upper respiratory infections and, in some instances, severe asthmatic attacks whenever they were faced with imminent separation. The physical component of the distress was evident in their restless agitation and in a progressive-like drifting and wandering in search of a gratifying object. The respiratory reactions and the agitated moving around can be considered as derivatives of the more primitive infantile appeal for help.

Since, as described earlier, there is a close dynamic correlation between depression and impulsive disorders, it is presumed, in either instance, that there is some defect in the ego. Bak (1953) conjectured, for example, that in fetishism there is a weakness of the ego structure which he attributed either to an inherent or secondarily physiological dysfunction or a disturbance in the mother-child relationship. Similarly Jacobson (1953) has presumed that in depression the ego has a specific weakness which is manifested by a vulnerable intolerance to frustration and disappointment. Neither writer, however, explained or described specifically the structural characteristics of this weak-

ness. Much earlier Freud (1938) selected fetishism as an illustrative example of the phenomenon of ego splitting which 'occurs under the influence of physical trauma', and when the ego 'is under the sway of powerful instinctual demand' (1938, p. 372).

Guntrip (1962) differentiated depression into two specific groups: (i) classic, stemming from guilt and repression of sadistic instincts; (ii) a depression which he likens to apathy that screens an underlying schizoid problem and is associated with a disturbed ego development, ego splitting and ego weakness. The latter group is prone to the dangers of regression and ego loss against which 'the individual exploits his active impulses in anti-social ways to counteract a deep compulsion to withdraw, break off object relations and risk losing the ego' (1962, p. 101). This conception is similar to the main hypothetical thesis of this presentation, namely that the impulsive sexual behaviour is a desperate defence against a disintegrative process in the ego. Guntrip assumes that the depression develops when this defence fails. This conclusion is only partially correct. As was apparent from the illustrated cases, depression was most instrumental in setting the anti-social behaviour into motion. Beneath the surface were marked feelings of helplessness, rage, and narcissistic anguish. This conception closely corresponds with Bibring's (1953) hypothesis that the core of depression consists of the ego's rage and shocking awareness of its helplessness in achieving its narcissistic aspiration which he defined as the 'need to get affection, to be loved, to be taken care of, to get the supplies'. The ego's susceptibility to helplessness, he presumed, was based on a fixation derived from childhood experiences which can be reactivated in later life situations which resemble the primary shock condition.

Sexually impulsive patients are predisposed to an infantile regression because of a fixation of a highly anacritic need in relation to a mothering object. Associated with such a primitive relationship are a poor differentiation between the self and the object, an insufficient neutralization of libidinal and aggressive impulses, a persevering operation of the primal processes of introjection and projection, and a polymorphous perverse predisposition. The anacritic fixation and the associated characteristics become partially or completely separated from the remaining ego, a phenomenon similar to Freud's (1919) conception of the genetic construction of the per-

versions. The postulation which is proposed here, however, is that this phenomenon is not only limited to the instincts but also includes the characteristics described above. Such a supposition corresponds with Federn's (1952) concept of the ego state which Weiss (1952) has described as a repressed ego component which 'has a specific content, emotional disposition, and urges' (p. 14). The persistence of such a primitive ego component deprives the remaining ego of a considerable amount of energy and thus interferes with the ego's full development. The degree of repression also influences the quality of the overall functioning of the ego. The less the repression, the more pervasive is the intermixture of infantile ego qualities with the remaining ego associated with a correspondingly increasing predisposition to primary process functioning.

Less often the primitive ego constellation is more successfully repressed, but even so is very vulnerable to frustration and disappointment. With the proper precipitant that is characteristic of such patients (as described above) the infantile component with its accompanying subjective feelings of narcissistic anguish and helplessness become intensely activated. The impulsive behaviour is then utilized as a means of alleviating the acute situation. The impulsive sexual behaviour evolves as a result of a regression and a splitting of the ego. The latter process permits a very early component of the ego to emerge while the remaining healthier ego is shunted into the background and is temporarily paralysed. The regression proceeds to an undifferentiated state in which the well-defined separation between the self and object representations collapses and there is then a fusion of both. The internal restitutional process then becomes externalized. Reality considerations are abandoned and the impelling aim, under these circumstances, is the pursuit for and the acquisition of an object willing and able to respond appropriately to the pregenital demands. When the object is attained, a transitory symbiotic fusion and a narcissistic identification are established. The pregenital (particularly oral) and narcissistic supplies are then fulfilled and the internal tension subsides. Comparatively, the sexually impulsive patient, like the manic, turns to the outside world to alleviate an internalized distress and the impulsivity is like the manic symptoms which, according to Katan (1953), 'serve to slow down or prevent a further development in a psychotic direction'.

In some instances the whole manoeuvre is temporary and reversible. In the regression the reality principle suffers, but it permits the fulfilment of the mobilized pregenital instinctual needs through an autonomous or heteronomous symbiosis via the polymorphous channels which are associated with the primitive ego component. As soon as homeostasis is re-established, the more mature ego then regains its mastery and can, once more, conform to the demands of reality. The regression in this type of patient can be compared to a regression in the service of the ego (Kris, 1951). In the sexually impulsive patient the regression, in conjunction with a splitting in the ego, facilitates a pregenital discharge and averts an inundation of the ego.

In a greater number of instances, however, such a manoeuvre is only partially successful. In such patients the pregenital needs are in a constant state of cathexis. Such a predisposition, perhaps, is attributable to a difference in constitution; or, more likely, to a very early disturbed mother-child relationship. Loss of a mothering object and lack of a suitable substitute in very early infancy (as in the first illustrated case) are very strong predisposing factors. In such patients, repression of the infantile component is very weak. In order to achieve even a minimal defence the manoeuvre has to be repeated frequently. The sexual impulsivity, therefore, is more severe and less controllable. Since the anti-social behaviour is inadequate as a defence, the depression which precipitates the process remains and disintegrative features, which the manoeuvre does not completely avoid, permeate the overall clinical picture.

The above theoretical considerations warrant a brief comment about their relationship to the problem of therapy. It is often difficult to determine from the diagnosis which patient will react favourably, since the sexual impulsivity during an acute period may be just as severe as in those who eventually prove unamenable to the usual psycho-analytical procedure. A trial analysis is often the only diagnostic tool through which such a judgement can be made. In most patients, the constancy, consistency, and availability of the analysis as a source of infantile narcissistic supplies, plus the patient's unconscious perception of the analyst as a pregenital maternal image who will somehow fulfil these needs, serve to restore a feeling of confidence and assurance. Concomitantly, there

is a diminution and often a complete cessation of the impulsive sexuality.

The stability which is achieved, however, is always tenuous and dependent upon the delicate balances in the transference interaction. In patients where the repression of the infantile component is relatively strong, though pre-genital ideation may continue, the impulse is not expressed in action and secondary process operation prevails. No prohibitions are necessary and the analysis can proceed in the classical manner. In the second case illustrated, for instance, the analysis lasted for five years, during which the former impulsivity was acted out only once and was precipitated when the terminal phase was initiated. Throughout the analysis repeated interpretation had markedly alleviated the symbiotic tendency, but with the prospect of termination the anxiety associated with imminent separation led to a temporary reactivation of the impulsive defence.

In patients where the repression is weak the pregenital needs are highly cathected (as for example, the first case illustrated) and the sexual impulsivity will continue as the analysis proceeds. They cannot tolerate the frustration of the classical procedure to which they react with marked rage and with threats of physical violence. The impulsive defence increases, and with it there is a gradual infiltration of primary process operation in their general behaviour. Such patients require a more active emotional support and evidence of the therapist's interest in them. In these patients, even with modification of the usual psycho-analytic technique, the general prognosis for therapeutic success should be guarded. Nonetheless, some improvement does occur, and the tendency to sexual impulsivity is reduced provided that the transference is not completely severed.

Conclusions and Summary

It has been proposed that imagined or actual loss or separation from a needed object precipitates marked separation anxiety, feeling of void,

aloneness, narcissistic anguish, depression, and impulsive sexuality. Metapsychologically, such consequences are related, most probably, to a very early disturbed mother-child relationship which promotes the fixation of an anacritically symbiotic need in relation to a mothering object. The symbiotic form of interpersonal transaction characterizes future interpersonal relationships with significant objects. The symbiotic need is the nucleus of a primitively fixated ego component which is characterized by a poor differentiation between self and object.

neutralization of libidinal and aggressive impulses, a persevering operation of the primary processes of introjection and projection, and a polymorphous predisposition. Frequently, the primitive ego component is successfully demarcated by repression from the remaining healthier ego; more generally, there is an intermixture of both. The latter is associated with a correspondingly increasing predisposition to primary process operation.

In either instance, such a primitive ego fixation is very vulnerable and can be easily activated by frustration and disappointment. The impulsive behaviour occurs as a result of a regression and splitting of the ego. The primitive component emerges and temporarily dominates the overall ego system. The undifferentiated and fused state between the self and the object is re-established. The sexual impulsivity evolves when the internal restitutional process, in response to economic necessity, is then externalized and gratified with an appropriate object. In this manner the internal distress is alleviated. The sexual impulsivity thus averts or lessens the danger of a psychotic disintegration. The success of the sexually impulsive manoeuvre as well as the treatment of such a disorder will depend on the strength of the repressive demarcation between the healthier ego and the more primitive ego component and the strength of the pregenital needs which are associated with it.

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versions. The postulation which is proposed here, however, is that this phenomenon is not only limited to the instincts but also includes the characteristics described above. Such a supposition corresponds with Federn's (1952) concept of the ego state which Weiss (1952) has described as a repressed ego component which 'has a specific content, emotional disposition, and urges' (p. 14). The persistence of such a primitive ego component deprives the remaining ego of a considerable amount of energy and thus interferes with the ego's full development. The degree of repression also influences the quality of the overall functioning of the ego. The less the repression, the more pervasive is the intermixture of infantile ego qualities with the remaining ego associated with a correspondingly increasing predisposition to primary process functioning.

Less often the primitive ego constellation is more successfully repressed, but even so is very vulnerable to frustration and disappointment. With the proper precipitant that is characteristic of such patients (as described above) the infantile component with its accompanying subjective feelings of narcissistic anguish and helplessness become intensely activated. The impulsive behaviour is then utilized as a means of alleviating the acute situation. The impulsive sexual behaviour evolves as a result of a regression and a splitting of the ego. The latter process permits a very early component of the ego to emerge while the remaining healthier ego is shunted into the background and is temporarily paralysed. The regression proceeds to an undifferentiated state in which the well-defined separation between the self and object representations collapses and there is then a fusion of both. The internal restitutional process then becomes externalized. Reality considerations are abandoned and the impelling aim, under these circumstances, is the pursuit for and the acquisition of an object willing and able to respond appropriately to the pregenital demands. When the object is attained, a transitory symbiotic fusion and a narcissistic identification are established. The pregenital (particularly oral) and narcissistic supplies are then fulfilled and the internal tension subsides. Comparatively, the sexually impulsive patient, like the manic, turns to the outside world to alleviate an internalized distress and the impulsivity is like the manic symptoms which, according to Katan (1953), 'serve to slow down or prevent a further development in a psychotic direction'.

In some instances the whole manoeuvre is temporary and reversible. In the regression the reality principle suffers, but it permits the fulfilment of the mobilized pregenital instinctual needs through an autonomous or heteronomous symbiosis via the polymorphous channels which are associated with the primitive ego component. As soon as homeostasis is re-established, the more mature ego then regains its mastery and can, once more, conform to the demands of reality. The regression in this type of patient can be compared to a regression in the service of the ego (Kris, 1951). In the sexually impulsive patient the regression, in conjunction with a splitting in the ego, facilitates a pregenital discharge and averts an inundation of the ego.

In a greater number of instances, however, such a manoeuvre is only partially successful. In such patients the pregenital needs are in a constant state of cathexis. Such a predisposition, perhaps, is attributable to a difference in constitution; or, more likely, to a very early disturbed mother-child relationship. Loss of a mothering object and lack of a suitable substitute in very early infancy (as in the first illustrated case) are very strong predisposing factors. In such patients, repression of the infantile component is very weak. In order to achieve even a minimal defence the manoeuvre has to be repeated frequently. The sexual impulsivity, therefore, is more severe and less controllable. Since the anti-social behaviour is inadequate as a defence, the depression which precipitates the process remains and disintegrative features, which the manoeuvre does not completely avoid, permeate the overall clinical picture.

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ACTIVATION OF MOURNING AND GROWTH BY PSYCHO-ANALYSIS

By

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In this paper we intend to present clinical evidence (1) for phenomena associated with pathological mourning as an adaptation to object-loss; and (2) showing how psycho-analytic treatment activated the mourning process and facilitated resumption of arrested development.

This paper is presented as part of the work of a group of analysts² studying the effect of object-loss in childhood on adult personality structure. This group research, called the Parent-loss Project, has been described in another paper (Fleming, 1962) which defines the special population of patients and the method of study. All the patients are chronological adults who have lost a parent by death in childhood. They are being treated by psycho-analysis, which offers an excellent method for observing the effect of various childhood experiences on the development of adult personality structure.

In the psycho-analytic situation childhood events are relived in the transference, and the vicissitudes of the ego's adaptation to the stresses of normal growth as well as to pathogenic experiences can be subjected to close scrutiny. Regressive and integrative processes become observable, and various developmental influences on the structuralizing of the ego can be studied through the testing of reconstructive inferences.

Our study has focused on the adaptation to loss of a significant object prior to maturity when the structure of the personality is more vulnerable to deprivation of an object needed to supply experiences essential for normal growth and development. In recent years there has been increasing emphasis on the importance of the object in the development of personality. This has been documented in both clinical and theoretical studies. Many authors have written

on the function of the object in normal development, and others on the effect of object deprivation as an interference with the developmental process. Most of these studies have been made on the mother-child relationship in early infancy, on longitudinal studies of child development, or on institutional or foster-home placement as it affects the growth of children. Very few reports have been made of observations on adults who have suffered the loss of an important libidinal object during the formative stages of the child's development. One of these studies, conducted by Hilgard and Newman (1959), was an important stimulus to our own work. They investigated anniversary reactions in adult patients who had lost a parent in childhood and who, after becoming parents themselves, developed a psychosis.

In a preliminary report (Fleming *et al.*, 1958), evidence was presented from the analyses of the first three cases in our series, which demonstrated a disturbed adaptation to the death of the parent. The immediate reaction was characterized by absence of grief at the time of loss, and denial of the reality was manifested in various forms. Efforts to adapt to the trauma resulted in uncompleted mourning work and what appeared to be a persisting immaturity. Patterns of immature behaviour seemed to be correlated with the level of development achieved by each patient at the time of loss. In our preliminary report, very rough correlations were made with generally accepted descriptions of phase-specific behaviour.

Since then, in a larger series of patients, correlations of adult behaviour patterns with developmental phases point towards an arrest of the normal process, especially in the area of ego-object relations. A striking picture of

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immaturity in self-image and in the development of ego-ideal and superego structures is apparent. Reality-testing, impulse control, object-need, and self-object awareness are not adequate for adult functioning in the patients studied. These manifestations of ego deficiencies seem to belong to levels of functioning more appropriate to different stages of childhood development. We encountered many difficulties in attempting to make an accurate diagnosis of phase-specific behaviour, as well as in formulating metapsychological concepts of age-adequate progress along significant lines of development. The recent work being done at the Hampstead Clinic by Anna Freud and her colleagues on profiles of development promises to be of great assistance in our investigation of adults. (Freud, A., 1962; Sandler, 1960; Sandler *et al.*, 1962; Sandler and Rosenblatt, 1962).

It was with the first case in our series, a 29-year-old woman who had lost both parents in middle adolescence, that recognition of these phenomena and their dynamics began to occur. The first clue was apparent in the failure of the transference to develop after the usual pattern. For some time this situation prevented our clear understanding of the patient's dynamics and the dynamics of the therapeutic relationship.

In the analytic situation, the defensive denial of the reality of loss was manifested in two ways; first, by negating the significance of the analyst in present reality, and second, by insistence on repeating with the analyst the fictional relationship with the lost parent. This state of affairs produced a transference resistance which interfered with the establishment of a therapeutic alliance as a basis for interpretation and working through. The patient's defensive balance demanded that no relationship with a new object could exist, especially on a new basis, because it would disturb the protective illusion and require the patient to face the painful fact of parental death and to resume the mourning work successfully avoided up to this time.

When we realized that giving the analyst any significance in her present life meant to her the establishment of a new relationship that would force her to give up her fantasy that her parents were still alive, we began to see the fixation and its defensive function, and knew the therapeutic task was to break through the defensive denial of loss and to complete the work of mourning. The mourning process had to be set in motion before analysable regressive transference neurosis could develop. In a number of cases we have

observed, once the resistance against mourning has been overcome, the analyst becomes important not only as a transference figure but as a new object useful in new integrations.

In this paper we offer clinical evidence from the analysis of one patient to show: (i) how the defence structure she had built up in response to the trauma of separation and loss of her parents delayed the development of an analysable transference in the first 270 hours of therapy; (ii) how this serious resistance was broken through; (iii) how the patient's investment of energy in a therapeutic relationship activated the mourning process with the recall of previously repressed memories and the experiencing of grief; (iv) how, when the mourning for the dead parents had been partially accomplished with much of the guilt for the ambivalence resolved, the patient began to work through her adolescent sexual conflict, which had continued to exist for 14 years on an early adolescent level; (v) growth and change began to occur with the achievement of insight into the denial mechanisms. Termination of the analysis reproduced the traumatic separation in the transference, but with a more integrated ego which could grieve and mourn for old losses and new separations without trying 'to make time stop'. Lastly, we would like to discuss the theoretical aspects of mourning derived from this case and how it correlates with the work of previous investigators.

Clinical Material

The patient, a 29-year-old woman, was an only child born in Germany, who separated from her parents at age 15. Her parents remained behind and were killed in the European massacre sometime around her eighteenth year. She entered analysis because of anxiety and depression, precipitated by failure to pass an examination in graduate school, and disappointment in a love affair.

In the early hours of the analysis, the picture unfolded of the adolescent quality of her 29-year-old character structure. These adolescent patterns and the typical early adolescent conflicts dominated the analysis. The pre-oedipal and oedipal material which comes into sharp focus in the usual analysis played a very subordinate role in this one.

However, since she was 29 years old, it did not occur to either of us to think of her as an adolescent in her character structure until the analysis had gone on for some time, and the difficulties in establishing an analysable trans-

ference became apparent. Even then we did not diagnose these difficulties as being born of the adolescent personality structure. The uncompleted mourning struck us first. The denial of the parents' death, the absence of grief for them, were observations which preceded the recognition of the extent and fixity of the persisting adolescent personality structure.

In the beginning of treatment, in what we later recognized as a characteristically adolescent attitude, the patient protested that she did not really need help—she was sure she could work out her problems by herself, although it might take longer. She felt that external circumstances were primarily responsible for her difficulties and insisted that everything would be all right if only she could have a satisfactory love affair.

In relating her history, she described her inability, up to the age of 29, to establish warm relationships with either men or women. She had few girl friends her own age. With her aunt she was defiant and rebellious, feeling that the aunt was trying to dominate her as she felt her mother had tried to do. With men she carried on a buddy-buddy relationship even when she had intercourse with them. She tended to avoid any close contact except in her fantasies, but became easily hurt and felt rejected when men turned away from her.

Prior to the age of 10 her memories were vague and meagre. The patient was fixed on the few years just before and after the separation from her parents, which she described as the longest span of her life. During the whole analysis very few memories were recovered that belonged to the earlier period, although it is more than likely that this period of time predisposed the patient to this type of defensive character structure.

Her emotional tone at the time of the separation from her parents appeared to be typical of some adolescents with a conflict over sexuality. Her romantic fantasies, which were about imaginary men, were always kept secret. Later she rejected any idea of having a man for herself and depreciated women whose only task is to have children and be housewives. She prided herself on her lack of breasts, her boyish figure, her masculine stride, and was considered arrogant, aggressive, and bossy by her friends. Keeping a diary was another pattern characteristic of her adolescence. She filled this diary with arguments between herself and her parents, and compared the need to write in the diary with 'the need to have a friend to whom you can tell

everything because after all there are some things that you can't discuss with your parents'.

It was in this atmosphere that the separation took place. Little information was reported about the decision to separate or the events and affects surrounding the separation itself until much later when the process of mourning for her parents was far advanced. Letters full of arguments continued the old type of relationship with her parents which had existed in Germany. She did not hear of their fate until after the war, although after 1942 her letters brought no reply. When people sympathized on hearing about her parents' death, she felt guilty because of her lack of obvious mourning. In fact, she occasionally had the fantasy that if they did come to England she might have to support them, and this she did not want to do. In the last few years prior to therapy, any conversation which brought thoughts about her parents evoked tears.

One of the difficult problems was the resistance of the patient to letting herself be aware of her involvement in the analysis. She talked about being afraid that she would be overwhelmed if she became fond of someone, and said that her feelings about the analyst were amorphous. Continuing along this line, she expressed the idea that the treatment had become a nuisance: 'It's silly to investigate some of these things; these are ideas I picked up in the course of my life and I just ought to shrug my shoulders about it'.

Around the 100th hour came the shift in the patient's recognition of the analyst as someone of importance to her. After being informed of the analyst's vacation, she had a dream of dying, being shunned and abandoned, and subsequently got depressed. When the relationship to the vacation was pointed out, she said she 'almost had a desire to be taken care of'. She thought of the analyst and then dismissed the thought. Shortly after this, she felt helpless and abandoned and, for the first time with any affect, began to talk about her parents. She began to realize that she was much more affected by their loss than she had thought.

Concurrent with her denial of the analyst's significance to her, she dreamed of her parents' being alive. In these dreams she was embroiled in arguments, trying to provoke them and feeling deprived. This seemed to support the defence of denial and to maintain the illusion of their existence. This illusion was continued in another form through the development of an affair with a married man. She acted out with him a fantasy of a relationship with an older man, and used it

as a resistance against an awareness of feelings and fantasies about the analyst. As long as the patient was able to continue to confuse the analyst with her friend B., she was able to confuse both the analyst and B. with the image of her father, and so deny father's death. As she began to feel frustrated in the relationship with B. and to recognize a need to repeat frustrating experiences, she became better able to differentiate between the analyst and B.

At about the 270th hour, using this greater differentiation on her part as a wedge, a suggestion was made that she stop the acting out. It was felt that she could tolerate this prohibition because she had become a little more involved in the analytic relationship. The patient became depressed, but in response to a transference interpretation got some recognition of the struggle with her parents at age 13.

At this point, the 280th hour, she brought in a fragment of a dream, 'I left the icebox door open and everything was defrosted. Things were beginning to spoil. I could not imagine why I had left it open'. This dream seemed to indicate that the defence of repetition in fantasies was no longer as effective as before.

In the next series of hours, as the analyst became increasingly recognizable as an important figure in the transference, the grief associated with the loss of the parents came to the surface, but was pushed aside. The patient reacted to the second annual vacation with the idea that she would miss the analyst but that it was futile to talk about it.

After this vacation she expressed directly the feeling that she was beginning to feel towards the analyst as a child feels towards her father. Also in hanging up her coat in the office, she felt like an intruder and remembered arguments with her mother. She dreamt of her parents in Germany. They had gone out without her and she was in a rage. In association to this dream, memories of what the parents had been like returned. She wondered if father preferred mother. As this material unfolded it was associated with more grief. She remarked, 'There are times when I wish my parents were alive and could see me now; it is agonizing to think that I will never see them again.' She said at this point, 'I've hit a new low,' and reported a confused dream, 'I didn't know where I was. I couldn't understand time.' She compared this dream to one she had just before entering analysis in which she awoke one morning and couldn't get up because she 'had forgotten her coordinates'. In looking

back this dream seemed to represent her fear of change, and an unconscious understanding of her problems, concurring as it did with her first step toward getting help for herself.

In relationship to feeling excluded and rejected in an affair, she wondered if this did not resemble some old feeling she had about her parents. When the analyst agreed, her response was, 'I won't see them again, I'll never see them again'. She began to cry and said, 'I must have loved them. I never wanted to look at that.' Then she wondered why she should have chosen that way to deal with her feelings about her parents—denial: 'It's back to the death of my parents.' This time the interpretation was made that as long as she could perpetuate the feelings of conflict with her parents, she could continue to reenact her pre-loss relationship with them and so continue to believe they were alive. In the 450th hour, on coming across a story of the War, the patient began to cry during the hour, with great affect, and asked, 'Am I belatedly mourning my parents?'

At this point, longer in duration than in many analyses, the relationship in the transference had opened up and activated a grief reaction that had previously been repressed. The task, at this point, was the resolution of the mourning for her parents in addition to the resolution of the normal conflicts of adolescence. Both involved separation for the sake of growth.

In response to the third vacation, a shift in conflict appeared. The patient focused more on the wish to separate two people in contrast to her former fear of being abandoned.

Material in the hours dealt with envy of her mother's hair, and a desire to be more feminine. In a dream, she was in the middle between a man and a woman and felt squeezed out. She suggested it would be better 'to walk with a woman on each side of the man', which was done. But she felt guilty because the man was holding her intimately. In association, she wondered if she ever felt this way about her parents, and then remembered the time when she got her own room. She felt both pleased and pushed out, 'A feeling of suddenly finding out that you have grown'.

This was very much the tone of her current life where she felt like a child on the fringe, and at the same time was able to act in a more feminine way with one of her male friends. Although she felt about to make a big jump, she still pictured herself in her fantasies with her parents hugging them and crying. She also had a fantasy of what

it would be like to meet the analyst in 10 or 20 years. Two events occurred concerning two friends she had known in London, where it was obvious to her that changes had taken place in them. She vigorously insisted that she herself was not going to grow. It was interpreted that she was having more and more difficulty in acting as if the world were the same as it had been when she was 15 years old.

During the last 18 months of treatment, there was an increasing elaboration and expression of the mourning process with recall of significant events related to the separation from her parents. Development of insight into her mechanism of denial was achieved, and with this achievement there was a more direct approach to her adolescent conflict. The patient no longer had to depreciate sexuality and competitive impulses. She began to talk about a man, C., with whom she had recently become intimate. She wanted the analyst to meet him, stating, 'I, too, can have a man'.

As she worked through this conflict of wanting a man of her own and choosing between C. and the analyst, she talked about her parents in a different way. 'At times I think it's a shame that I never knew them when I was grown and they didn't know me.' Here is evidence of acceptance of their death and movement towards the conflicts of later adolescence, with a beginning of detachment of libido from the parental images and making it available for new objects. Some of this energy was attached to the analyst as she used the latter for a transference object to work out her adolescent struggle for emancipation and growth. Here, on the stage of a basic positive relationship, she acted out her adolescent rebelliousness with simultaneous fears of steps towards adulthood. She was feeling rebellious towards the analyst as she planned to move into a new apartment. She reported a dream of some teen-age kids all behaving in a noisy, violent fashion, but she was different. She began talking about ending the analysis, but in no concrete way.

Much of the conflict at this stage of the analysis could be described as the patient's efforts to grow. Steps were made forward, followed by retreat, refusing temporarily to accept the real changes that were taking place in her job, personal life, physical characteristics, and general sense of well-being. In association to her rebellious feelings towards the analyst the patient talked about her rebellious feelings towards her parents with a new insight that in a later stage of development one can see one's parents as

people. She had never felt this, but had always taken them for granted.

The conflict about growth continued. It was associated with the expression of grief and increasing perception of the present-day situation. She felt deprived of her parents, but 'I refuse to have their place taken'. In association to a dream of a power struggle with her mother, she said tearfully, 'I don't let my parents die'. She began to think about the separation for the sake of her own growth as excluding the parents. Around the time of the fourth vacation, she reported a dream of phoning her father in London, but with the perception that he should be dead. On a vacation of her own, she felt desolate although rebellious. This feeling was associated with the fear that the analyst would not be there on her return. This was interpreted as her fear of the repetition of the real experience. Once she left her parents and had never seen them again. Her reply was, 'I thought it would only be for two or three months. How could I get so fouled up? This business of being stuck somewhere without wanting to grow. I feel ashamed of it. It makes me feel inadequate, that I'm not able to cope with my problems better than by refusing to grow up.' The reality of the danger in the European situation in 1939 came up. It was interpreted to the patient that she needed to separate from her parents to survive, and that they sent her away so that she could survive. Her associations were, 'They must have been more aware of the danger than I.' 'I have to live in the present, and I've never done this.'

After the summer vacation, the patient informed the analyst that she had put in motion an application for restitution from the German government. This was possible because she was accepting the fact of their death. She had a feeling of being on the fence and did not want to jump. She began to bring up the idea of approaching the end of treatment, but 'I have some things to work out. It's not a problem of growing up, but it's accepting myself as I am. I'm still up, but I'm still not satisfied it's too bad. I could always look to the future as before. I kept myself happy by this. Maybe I'm just postponing the moment when I may not like some of these things.' She began to have a growing awareness of the passage of time, and made the remark, 'I've lost a lot of time—18 years.'

There was, concurrently with this, a growing awareness of the analyst as a person. 'You must have got a lot of pleasure out of fixing this room

up. You like it and spend a lot of time here. I'm very pleased, we have something in common. I fix my room, you fix yours.' This whole period of struggle about growth culminated in a dream. The patient made a point of saying she dreamt her parents were alive. She was away somewhere on a camping trip. Then she got a phone call that was from her grandmother. Grandmother was beating about the bush regarding some bad news. Patient knew it was about her parents. Grandmother did not want to tell her. She asked the patient on the phone to come back, and the patient said, 'For Christ's sake tell me.' She was in a panic—something had happened to her parents. Even in the dream she was amazed at her own feeling and was horrified when she learned that they had been killed in an automobile accident. She was grief-stricken even though she knew it was a dream, and she was amazed at the intensity of what she felt. When she awoke she said, 'Good heavens, can you imagine such intensity of feeling so many years later?'

As the patient worked on the resolution of her mourning and her adolescent conflicts, the significance of the sense of danger previously experienced in the analysis became more apparent: namely, the importance of her guilt over her wish to separate from her parents, and the part it played in her need to deny their death which followed on leaving them. She talked about feeling guilty because of doing so well in her personal life and in her job. When the analyst remarked that she associated things going well with her to the loss of her parents, she replied, 'I thought you meant that things were going well *because* I lost my parents.' This she associated to a feeling of liberation. 'It's a good idea at 16 to separate from your parents', she said, but she was doubtful what she would say about it now because her separation was a 'complete loss'. But if her parents were alive this would limit her ambitions, and about this she felt guilty. At this time, the patient was concerned with the question, what is wrong with having loving or affectionate feelings towards the analyst or her father? At the same time she felt rage when she got no response from C., or the analyst, and remembered similar feelings towards her father when she was a small child. All this was related to thoughts of terminating the analytic relationship, which the patient compared to leaving her parents. She was afraid of being on her own, felt guilty about leaving the analyst behind, and had an increasing insight

into the way in which she handled her fear and her guilt. 'At some point when I left my parents there was something that was so unbearable, it stopped the clock. I couldn't keep the outward circumstances constant so I kept the inward ones constant.' When the analyst remarked that it looked as if the clock was starting, the patient reported changes in her personal habits. She felt on her own now. She had the feeling that she had something to settle with the analyst, and remarked that as an adolescent she did not feel afraid. The analyst asked what she was afraid of repeating with him, and she replied, 'That rings a bell, but what? Why was I stuck about feelings about father? It's O.K. for teens but why didn't I grow? Is the clock stopped? What was too painful? To avoid realizing that they were dead—did I have to stop everything?'

Under the pressure of guilt about termination, the patient retreated and again denied caring about people she might be leaving behind. 'In due course I'll be leaving this city without caring the least about leaving anybody.' But soon after this she began to talk about whether she was important to the analyst, would the analyst remember her? She felt she had grown beyond C. The analyst made a transference interpretation that she was repeating conflicts which existed before she separated from her parents, which had to do with the desire to surpass her mother. She was guilty about this and yet she wanted to be special. In a way she had been special because she was saved and they were not. Therefore she has to continue living over and over the conflict with her parents in order to master the guilt of her own survival and their death. The reaction to this interpretation was a wish to cry, 'You hit it right. The guilt before separation—it's true, I wanted to be independent and I was not upset when I left them. When mother cried I was ashamed that I had no response.' The analyst said, 'But one of your wishes was to go away.' Her remark was, 'The final separation—there was a lot wrong with it, especially the way it occurred—it could have been such fun to go away and come home.'

When the patient wanted to take a vacation from the analysis, the analyst questioned her motivations and wondered if it was advisable. Again she became rebellious, as if the analyst were holding her down and not giving her her freedom. This led to the recall of 'After I left my parents, I was forever in rebellion. This is typical of teen-agers but not of the thirties, or should not be, but I enjoyed it. I was proud of it.'

I resent talking to you. I was glad when I left home, I felt free. But I was guilty later when my parents were killed. Every time something comes up about being glad to leave, it adds to the feeling that it had not been nice of me. It's a shame that my parents couldn't understand me as a teen-ager, but I guess they were just human too.' It was interpreted that she did not want to change but wanted to keep herself in this position because to grow and be free meant something destructive to her parents and also to herself.

After this she began to have a more realistic approach to what father and mother had been like. Specifically, she began to talk about father, wondering why he did not get out of Germany. Everyone knew that the end was coming, even when he left he did not really get out. Then she remembered a picture of mother at her prayers, 'Several times I caught her crying. I used to be pretty upset, but it's likely I pretended not to know.' The patient began to cry and said, 'It's strange, I never realized that I loved my mother until this minute.' She had a picture of mother crying and praying and wished that she could do something for her, as though it were now.

Following this, she experienced an important transference reaction. She wondered about the separation from her parents. 'For it to have had such an effect there must have been some weak spots in the relationship with them. Is that right?' she asked. When the analyst said, 'It sure is,' she had a feeling the analyst was laughing at her for trying to make interpretations and feeling able to do what the analyst does. 'Will I ever be able to stand on my own two feet again? It's funny that I added "again".' She had the idea she was beginning to finish and realized she was afraid. She began to talk about giving up her own work and going into psychology instead. She was somewhat ashamed and embarrassed to talk about this. The analyst said she was talking about the same thing that he does, and that this was a problem never worked out with her mother, namely, being able to do the same thing as well or better. She continued to ruminate about feeling guilty about growing, 'But I don't want to be an analyst,' she protested. She then had a splurge of activity in which she functioned well but presented herself as afraid of finishing. She began to talk about the positive values of finishing—more time and money for herself. The analyst interpreted that she was afraid to face these feelings because of some idea that it was associated with destruction.

At this time she felt that the analyst had cancelled some hours deliberately as a way of cutting down without it seeming to be so. The analyst pointed out her need to see this as being done surreptitiously. This would solve the conflict about her wish to leave the analyst behind and make it seem as if there had been no parting.

The problem discussed here becomes clearer in another dream about doodling. She had a piece of paper and a pencil—she was talking and doodling, 'It meant something to you because you took the paper and looked at it. It was very valuable because at that session things became clarified without my having to do much about it. The doodle was more important than what I had said.' The analyst remarked that he thought she had already made her decision and that she could not communicate it directly but only by the doodle. The patient said, 'I wonder what it could be. The only thing is how much longer am I going to come here?' She felt blocked and frightened at this point, but when asked, 'What date did you have in mind?' she said, 'It's very close, maybe by the time summer is over. The time that actually occurred to me was when you go on your vacation. I never put a date on it before. I thought about it being at the end of the summer before but this time it's different.'

When she continued to talk about separation from her parents, the analyst asked her about that date. She gave the date and compared it to leaving the Zionist farm to go to London a year later. Going to London really was permanent, but she wanted it to look like a vacation. The analyst remarked, 'It sounds like the problem you have about leaving analysis. You feel guilty about the idea that you might never see me again.' She said, 'I've done this for years,' felt sad, depressed, and began to talk again about finishing. When the analyst interpreted that if someone is out of sight they do not exist any more, she remarked, 'Something occurs to me: it seems I got stuck when my parents and I separated and I didn't see them any more. After a certain number of years they ceased to exist actually. This was a shock. It seems as though I got fixed on this reaction and I react to everyone in this way; why should I unless I was guilty or felt responsible for what happened? I had a thought—it just hit now—they did it for me. They sent me to England by myself and I was better off materially than if they came with me.' The analyst remarked that she felt guilty about the mere fact that she had survived. She said, 'That goes for the money and survival.'

The subsequent material had to do with the patient's denial and delay in facing the termination, and her associations and interpretations about the meaning of this. Of equal importance is the patient's participation in setting the procedure for termination. On 3 June the patient was informed that the analyst's vacation was to begin on 15 July. Her reaction to this was, 'It seems so soon. I just won't terminate then.' She began to talk about 'How do you finish? Do you come less frequently?' She did not want to decide because she would never be certain whether the analyst had approved. She wondered if she would be just as upset if she quit before the time to terminate. Her indecision about making a decision came up in association with the original idea of going to England. She realized that she had had quite a bit to do with it—her parents brought it up but she liked it since she was not the least bit eager to go to Poland with them. She wondered, 'Will I actually finish on the fifteenth?'

She came in on the anniversary of her separation from her parents all tired out and depressed. She was about to repeat the dawdling of the day before, 'What do you do at the end? Do you throw a party?' C. said, 'Take a bottle of wine to the hour.' The analyst felt the patient did not recognize the date and its significance. When he asked if she knew what day it was, she gave the date and remarked, 'Good heavens, I didn't remember. Now I'm crying. That must be why I resented C. going home today.'

This awareness enabled her to talk about the last day with her parents. She remembered them on the platform crying. She had no regret and felt terrible about this. It was necessary to change trains in Frankfurt and the officials were very disagreeable. When the refugees crossed the border, they were welcomed by a group of Dutch people, tea, food and great rejoicing. When she got to England she was confused and could not take care of her luggage. On this anniversary in 1957 she said, 'I must have been remembering all of this yesterday without realizing it, and that's why I got up at 6 o'clock. I was thinking of father and mother, how old they would have been now. Father would be 57 now. The last 17 years have gone so fast—faster in memory than the first 17 years. I don't remember, but this is sort of an anniversary—exactly 18 years, or is it 17? I can't do the arithmetic! It's really 18.'

She began to look more grown-up and feminine at this point, and continued to talk about

terminating, 'I can't visualize that this is the end. Yet it's going to be very soon. I'm not able to decide.' She confused C. with the analyst frequently at this point, and it was interpreted that she was trying to avoid the intensity of her feelings about leaving the analyst. 'I can't feel it's right—I should say, I can't feel it's wrong.' She then talked about leaving England again, began to ruminate about a coat of her mother's and wondered whether it would fit her now. She talked about finishing in a month; 'Maybe I will and then I'll just see you a couple of times.' The analyst agreed with the wisdom of this procedure, which would in this way avoid a separation too identical with the separation from her parents.

Then came a long dream, indicating some integration of herself in time and in present reality. She was back in Munich with her parents. They left and called to her, 'Aren't you coming?' She said, 'I'm going to stay another day.' Then she looked through the apartment, talked about the living-room with windows a little high, 'I was surprised to be my present age in the dream but when I say this about the windows that might be how it would look to a child.' Then she investigated the apartment and found a telephone which in reality they did not have. She wanted to call someone, but she did not quite know whom to call. Then she did not remember the number; 'After all, it's been 17 years.' Then the dream changed and there was the idea that her parents were dead. She thought of looking up people who were still there. This was both pleasant and painful. She thought of some teachers, but they were old and might also be dead. Then she reported another dream, back in Munich, but it looked like London. She did not mind walking by herself after dark, but she was hungry. She talked to someone; German was spoken, but without any fluency on her part. There were lots of stands for snacks, but none seemed to have what she wanted. One had the remains of a sign in English, 'It must have been from the war—an American hot dog stand, and I was annoyed that it was not there any more.'

She felt this dream meant, 'I was finally making my peace, a final step.' She continued to talk about her guilt for leaving her parents. The analyst pointed out the termination was difficult for her because it looked as if she took all of her mother's talent by growing. She said, 'I can't remember, but what I think seems to confirm this. I'm pleased to look like a woman. I want everyone to notice my weight, my legs, my waist.' Then she talked about being surprised that the

analyst took her seriously about the termination date. 'The status quo is over, I can't postpone any longer. Treatment is beyond the point of usefulness, it's prolonging the dependence relationship that's no longer necessary. I've grown fond of you and the idea of not seeing you is going to be painful. Now I want to cry.' She then talked about setting a definite time to see the analyst after she terminated, and the analyst agreed that they would make an appointment sometime in September when she returned from her vacation.

In characteristic fashion her next remarks demonstrated the persistent drive to keep a separation from the analyst as identical as possible with the separation from the parents. She said, 'Do I kiss you goodbye? I presume I kissed my parents goodbye.' People suggested to her that she ought to celebrate about finishing treatment. She said there was nothing to celebrate. The analyst remarked that there was some sadness. She said she ought to be able to answer yes, but she feels none, as if she must again repress her emotions. 'It's foolish to cry or be upset because one is finishing. Everyone else reacts that it's nice and they're happy, and so it is in a way, but on another level I have nothing to celebrate. It's odd to feel this way about someone that you know in such a limited contact.'

It should be emphasized that five or six weeks prior to the termination of the analysis was the anniversary of the first weeks in England and the period immediately following the separation from her parents.

She began to talk about what she would do in the last hour. Would she sit up? It would be difficult. The analyst pointed out how she wanted to make the last hour like all the others. She said, 'Sitting opposite you I'd be tongue-tied. When someone you're fond of leaves you get upset. I'm sorry that it's coming to an end; I can't face it. It's only half real—it isn't true. It's absurd to be upset on leaving one's psycho-analyst. I've tried to make a joke out of it. Maybe there is a parallel between leaving my parents. There's something inevitable about this separation just as there is with parents and children—only mostly they're not quite so drastic. But this is inevitable, natural and right, so I have no right to be unhappy.' The analyst agreed with her that there was a parallel between her feelings for the analyst and her parents, but the same thing was actually not happening. She was close to tears, and said, 'What difference does it make?' The analyst pointed out that unhappiness was not all

she felt. When she had said it was inevitable, natural, and right, there was some gratification in leaving. She said, 'It's true, I don't feel it when I'm here, but it's uppermost in my mind when I'm away. Do I feel guilty?' She would like to know the analyst socially. Separation and breaking up in any kind of contact one has valued had always been difficult for her. She thought it would be difficult to imagine not liking the analyst.

Patient then returned to the question about making an appointment after she had finished. She wondered what she was afraid of. The analyst remarked, 'You're not really sure you'll ever see me again.' The patient's response was, 'It looks like it', and was close to tears.

The last hour the patient came in and emphasized the convenience of not having to come any more. 'It's your turn to talk now.' She said she had learned a lot 'but that is not the primary purpose of treatment; the rest, I feel, is intangible. It would be funny to mention to C. that this is the most prolonged relationship I've had. The word I wanted was the first mature relationship. How do you say goodbye? Do you shake hands? I should have brought flowers. As I was coming I thought this was the last time and I was glad. When I'm here it's all so different—it's mostly sad at the parting and some fear. It's easier to talk to you. It stops me from deceiving myself.' Then she talked about teenagers growing up whether they want to or not.

At the end of the hour an appointment was made for the last week of September, following the vacation. The analyst remarked that he had enjoyed working with her. They shook hands, the analyst wished her luck, and they said goodbye with some feeling of sadness on both sides.

When the patient returned in September she reported that she had 'had a lousy summer'. For two weeks she felt acutely bad and then the rest of the summer was generally miserable. She told about difficulties with C. till the last week when he was leaving town. This was interpreted as reliving the separation from her parents and wondering if the analyst would be able to survive the change in the relationship. 'Even if I try to put you into a fantasy, there is no place for you.' She had been thinking about her parents in the last three weeks, with sadness about never having known them as an adult.

Patient readily agreed to come a few times to talk the situation over. The analyst interpreted that what she called her relapse was due to a

problem about leaving the analyst, that she could not allow herself to feel because she had fears of a total dissolution of the relationship with the analyst rather than a change. She said, 'But separations were always permanent, like with my parents, and leaving London.'

The patient felt better immediately after the return visit and had a dream about two men in which she had to make a choice. She chose the man associated with C. and not the one associated with the analyst. She talked about wanting to know the analyst in the future, but had no regrets in the dream about her choice. She felt much better about herself at this point.

The patient was impressed with the change in her feelings following these return visits. She realized that the interruption and return had been necessary in order for her to accept the change in herself. She said not to return would have left something undone. In the treatment her idea that learning and growing meant the destruction of her parents 'became untwisted'. 'The way I handled it then was maybe the only way but not very good. This is a better way.'

Discussion

We have described the course of an analysis of a 29-year-old woman whose maturation was complicated by the death of her parents during her adolescence. This traumatic event had intensified the adolescent development task of emotional and social emancipation from childhood parental relationships. The mechanisms by which she adapted to this experience included denial of the reality of her loss and of the passage of time. This adaptive effort resulted in a prolonging of adolescent behaviour patterns and a failure to complete either the mourning for her parents or the normal resolution of her developmental conflicts.

This arrested development and uncompleted mourning presented an unusually difficult resistance and distortion of the development of the transference neurosis. Our material confirmed what Anna Freud described in her article on adolescence (A. Freud, 1958). Here she pointed out how attempts to analyse an adolescent often met this kind of resistance, an inability to cathect the analyst and so to establish a basic transference from which the analytic work can proceed. According to Anna Freud, growth in

this period normally requires a withdrawal of cathexis from the parent similar to what is required in mourning work, but so much energy is needed for this adolescent developmental task that not enough is available to cathect objects involving new levels of relationship.

In our patient, the demands inherent in the tasks of emancipation and mourning occurred simultaneously and required an integrative capacity which the patient did not possess. She managed to function well for fourteen years as long as the pressures for further sexual and social growth remained fairly constant. However, when life forces urged adult sexuality and career roles on her, adaptations to stresses of adolescence and to the trauma of parental loss broke down. At this point she was able to seek and eventually use outside help. Only after the repressed grief and ambivalence for the parents was mobilized through the repetition of separation experiences in the analytic transference could a new resolution to her adolescent conflicts be achieved. Analysis of the initial transference resistance activated the uncompleted mourning process and permitted the patient to proceed with her interrupted development. The most significant working through was accomplished in the experience of termination and consequently separation with emancipation from the analyst. The termination of this relationship differentiated him and the analytic experience from what had occurred with her parents, and freed her from the defensive fixation which had arrested the process of maturation in this patient. She was able to accept the death of her parents without ambivalence and guilt and to gain a new self identity with an orientation in present time.

Repression of grief has been described by³ Helene Deutsch (1937). She explains the absence of expressions of grief or awareness of the feeling as the ego's defensive attempt to preserve itself in the face of overwhelming anxiety. Death of a libidinal object is experienced as separation from a needed source of supply. the loss of which threatens the self. The intensity of the danger depends upon the degree of helplessness experienced in the separation. The more immature the ego, the more needed is the object and consequently, more intense anxiety will be experienced as a result of the loss. Deutsch emphasizes the importance of ambivalence and

³ Pollock, in discussing an earlier presentation of this material before the Chicago Psychoanalytic Society, pointed out that the developing transference neurosis is atypical not only because the patient cannot accept the

death but because accepting the death unleashes the guilt and other ambivalent feelings associated with the object that is deceased.

unneutralized aggression present in the pre-loss relationship as a factor in determining the quantity of stress to which the ego must adapt.

In *Mourning and Melancholia* (1917), Freud develops the concept of mourning as a process whose aim is adaptation to the loss of a loved object. It is a process which continues over a period of time, has stages in its operation, and a goal resulting in a modification of ego organization. He called this process mourning work, whose task is to shift libidinal cathexes from their attachment to the lost object and make this energy available for use in new relationships.

Partial and temporary separations from libidinal objects are experiences which from birth possess significance as activators of the adaptive mechanisms of the ego. To a large extent these separation experiences influence the rate and direction of growth, and play a part in organizing the developing ego structure. Thus the process of growth and maturation can be compared to mourning work in that every step towards maturation involves some adaptation to separation, and therefore some mourning work. In true mourning, however, the separation is total, whereas in normal growth the maturing separation more often involves detachment from an old pattern of relationship while the real object continues to exist and the step forward is in terms of change and giving up rather than losing something. Freud, in *The Ego and the Id* (1923), described this developmental process most succinctly when he said, 'the character of the ego is a precipitate of abandoned object-cathexes and... contains the history of those object-choices.'

Spitz (1957) and others have demonstrated that the presence of adequate objects is essential for the earliest organization of the ego. Many authors, A. Freud (1944), Benedek (1938, 1956), and others have described at length the importance of the mother as a part object, then as a differentiated object essential for the experiences which structure the child's sense of self and the ego's patterns of adaptation to reality. Meiss (1952), in reporting on a five-year-old boy whose father died when he was three, emphasizes the need for objects of both sexes when the integrative tasks of the oedipal period are at their height. She describes how her patient attempted to provide himself first with his own father through imagination and then with an actual substitute father in a transference triangle with her.

The disturbing effect of object loss on ego

development has also been described by many other authors. Rochlin (1953), stresses the length to which the child's ego will go to make up for the deficiency caused by the absence of a needed object. In his case, the loss occurred very early in the little boy's relationship with his mother when his need for narcissistic sustenance from her was still paramount and even before his perception of her as more than a part object was well organized. His solution was to withdraw to social isolation but in contact with a symbolic object in the form of his mother's fur coat. She did not die but she withdrew from her son, and the substitute caretakers did not supply the experiences of emotional response necessary to change narcissistic libido into object libido. Rochlin emphasizes that withdrawal to the self is not enough when an externally existing object is needed by the immature ego. The needed object is strenuously sought for to prevent disintegration of the self. This may be accomplished at the cost of a rupture with reality (Freud, 1924). In *The Ego and the Id* (1923), Freud describes the 'reinstatement of the object in the ego' in reaction to loss, and says that this introjection results in a modification of the ego.

In agreement with these and other authors, we felt that the failure to mature was largely due to the absence of a libidinal object whose presence was necessary for the ego's growth towards normal maturation.

In our preliminary report and in this case, it seemed to us that two things had occurred as the immature ego began its work of adaptation to parental death. First, the loss of the love object was experienced by the ego as a danger to itself and reacted to with denial of reality, denial of the absence of the parent, and concomitant repression of affect. The second adaptive mechanism set in motion by this overwhelming situation seemed to result not only in absence of grief but in pathological mourning which could be described as prolonged and still incomplete at the onset of analytic therapy many years after the traumatic loss occurred. These defences of repression and denial of perceptual reality, accompanied by fantasied continuation of the lost relationship, constitute the early stages of a normal mourning process. When prolonged, they absorb the energy necessary for growth and the establishment of new relationships in the present. Pollock (1961) has recently focused on the usual adaptive function of mourning work in bringing about new integrations after the loss of a significant figure. This contrasts with the adaptive

function that resistance to mourning serves in the patient under discussion here.

Bowlby, in his recent series of articles on separation anxiety, has described observations of the sequence of behaviour which commonly occurs when children between the ages of about 12 months and 4 years are removed from the mother figure to whom they are attached and placed in the care of strangers. These behavioural sequences have been termed by Robertson and Bowlby: protest, despair, and detachment. Protest is associated with the problem of separation anxiety, despair with grief and mourning, and detachment with defence and future psychopathology (Bowlby, 1960a, 1960b, 1960c, 1961).

These concepts of Bowlby's have aroused controversy as to whether these reactions can properly be termed mourning. The basis of the controversy is whether sufficient structural development has taken place in the still maturing ego for mourning for a lost object to occur, or whether this is simply a separation reaction to loss of a need-satisfying or part object (A. Freud, 1960; Schur, 1960; Spitz, 1960). These questions, of course, must wait further clarification of concepts of ego development and structure before a definitive answer can be reached.

Bowlby has also postulated that the term mourning should not be confined only to those cases of successful mourning (Bowlby, 1961). Using this broader definition, Bowlby's patients certainly are undergoing a mourning process, but a process which may become interrupted in a particular phase. This interruption may be an arrested state, as where the resistance against the work of detachment was especially demonstrated in our patient. The phase of protest and despair may be successfully managed, but the phase of detachment requires an integrative effort not always possible or in which the mechanisms used result ultimately in some form of pathology.

Our patient gave no evidence of any acute reaction, such as protest or despair, to the loss of her parents. In fact, she reported feeling no grief, much as Helene Deutsch's patients did (Deutsch, 1937). It would seem that the vigorous and lengthy denial of the loss certainly carries in it 'protest'. Moreover, upon the activation of mourning, despair was felt by the patient. 'I won't see them again. I'll never see them again,' and 'I must have loved them. I never wanted to look at that.'

Freud, in *Mourning and Melancholia*, defines decathexis of the lost object and the freeing of energy for new objects as the essential integrative task. When achieved it brings an end to mourn-

ing. Our patient in the light of these definitions must be seen as unable to mourn successfully, but as continuing a pathological mourning process in that she could not accomplish the decathexis of the lost objects. Her failure resulted in incomplete mourning, and confirms the observation of Bowlby that the stage of detachment is difficult to work through. His findings (1961) indicate that serious psychopathology may appear during this stage of the mourning process.

Investigation of the mourning process in cases of adults whose loss occurred in childhood many years before coming under observation, offers a fertile field for the study of the normal and pathological aspects of this important experience. It is an experience which confronts the child with demands on his integrative resources that bring those specific stresses and corresponding adaptations into clear focus when observed in the transference repetitions of a psycho-analytic situation. Genetic reconstructions of the childhood vicissitudes of development and a given child's methods of adaptation become possible. The resulting personality structure can be correlated with the childhood trauma and its various dynamics identified. Such information is available otherwise only in long-term studies of a child while living through such an experience over a period of many years. Information from both types of studies should contribute valuable data for metapsychological concepts regarding the function of the object personality development as seen through studies of object loss.

Conclusion

The course of an analysis of a 29-year-old woman is presented, which demonstrates a form of pathological mourning; that of the defensive denial of the reality of the parental loss resulting in prolonged mourning and interference with successful maturation. This adaptive equilibrium persisted for 14 years with a continuation of adolescent developmental conflicts and personality structure. Psycho-analytic treatment was able to penetrate the defensive denial, activate the interrupted mourning work, and help the patient to resume the growth process interrupted at age 15, with resolution of adolescent conflicts and new integrations. This complex of prolonged mourning and developmental fixation is discussed in terms of adolescent developmental tasks and in relationship to mourning, growth, and the pathological consequences of unfinished mourning.

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THE CONCEPT OF TRANSFERENCE

By

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I. A LOGICAL ANALYSIS

Transference is one of the most significant concepts in psycho-analysis. It is therefore especially important that its meaning be clear, and its use precise. In this essay, my aim is to present a brief analysis of the principal meanings and uses of this concept. This contribution is part of a larger effort whose aim is to identify those activities that are specifically psycho-analytic, and thus distinguish psycho-analysis from other forms of psychotherapy (Szasz, 1957b, 1961).

Potentially, the subject of transference is as large as psycho-analysis itself. To make our task more manageable, I shall discuss transference under five separate headings as follows: (i) Transference and reality; (ii) transference in the analytic situation and outside it; (iii) transference and transference neurosis; (iv) transference as the analyst's judgement and as the patient's experience; (v) transference and learning.

Transference and Reality

Logically, transference is similar to such concepts as delusion, illusion, and phantasy: each is defined by contrasting it with 'reality'. Freud's (1914) classic paradigm of transference, it will be recalled, was the phenomenon of transference love—that is, the female patient's falling in love with the male therapist. Just what is this phenomenon? According to the patient, it is being in love with the analyst; according to Freud (1916-17), it is an illusion:

The new fact which we are thus unwillingly compelled to recognize we call *transference*. By this we mean a transference of feelings on to the person of the physician, because we do not believe that the situation in the treatment can account for the origin of such feelings (p. 384).

We have encountered this distinction elsewhere: between imaginary and real pain, and between psychogenic and physical pain (Szasz, 1957a). In these cases there is a conflict of opinion between patient and physician, which is not resolved by examination of the merits of the two views, but rather by the physician's autocratic judgement: his view is correct, and is considered 'reality'; the patient's view is incorrect, and is considered 'transference'.

This idea is expressed by Nunberg (1951), when, in reply to the question, 'What is transference?' he asserts:

Transference is a projection. The term 'projection' means that the patient's inner and unconscious relations with his first libidinal objects are externalized. In the transference situation the analyst tries to unmask the projections or externalizations whenever they appear during the treatment (p. 1).

This view is uncritically repeated in every discussion of the subject. The most trivial examples of 'misidentification' are brought forward, again and again, as if they revealed something new. An excerpt from a recent paper by Spitz (1956) is illustrative:

Take the case of that female patient of mine who, after nearly a year's analysis with me, in connection with a dream, expressed the opinion that I was the owner of a head of rich, somewhat curly brown hair. Confronting her with the sorry *reality* made it easy to lead her to the insight that the proprietor of that tonsorial adornment was her father, and thus to achieve one little step in the clarification of her insight both in regard to the emotions she felt towards me and to those which she had

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originally felt towards her father (*italics added*; p. 384).

On the face of it, there is nothing wrong with this account. But this is so only because the analyst's perception of the 'facts' is so obviously more accurate than the patient's. This obscures the complexities and pitfalls inherent in the tactic of classifying the analyst's view as reality, and the patient's as unreality (Fenichel, 1941). Here is a more challenging situation: the analyst believes that he is kindly and sympathetic, but the patient thinks that he is arrogant and self-seeking. Who shall say now which is 'reality' and which 'transference'? The point is that the analyst does not find the patient's reactions pre-labelled, as it were; on the contrary, he must do the labelling himself. Hence, Nunberg's (1951) distinction between analytic and non-analytic work does not help much:

The psycho-analyst and the non-psycho-analyst differ in their treatment and understanding of this phenomenon, in that the former treats the transference symptoms as *illusions* while the latter takes them at their face value, i.e., as *realities* (*italics added*; p. 4).

There is no denying, however, that the distinction between transference and reality is useful for psycho-analytic work. But so is the distinction between real pain and imaginary pain for the work of the internist or the surgeon. Practical utility and epistemological clarity are two different matters. Workmanlike use of the concept of transference should not blind us to the fact that the term is not a neutral description but rather the analyst's judgement of the patient's behaviour.

Transference in the Analytical Situation and outside it

There has been much discussion in the psycho-analytic literature about the precise relation between transference and the analytic situation. Freud emphasized from the outset that man's tendency to form transferences is universal. Only the use we make of it is specific for analysis. Glover (1939) states this view succinctly:

As the transference develops, feelings originally associated with parental figures are displaced to the analyst, and the analytic situation is reacted to as an infantile one. The process of transference is of course not limited to the psycho-analytic situation. It plays a

part and a useful part in all human relations whether with concrete objects (both animate and inanimate) or abstract 'objects' (ideas). Hence, it is responsible for the most astonishing variations in the range of interest manifested by different individuals or by the same individual at different times (p. 75).

Despite the clarity and simplicity of this view, many analysts have tried to redefine transference as a uniquely analytic phenomenon. Two classes of transferences are thus created: one analytic, the other non-analytic.

Macalpine (1950) defines analytic transference as 'a person's gradual adaptation by regression to the infantile analytic setting'. Waelder (1956) also emphasizes the specificity of the analytic setting on the development of (analytic) transference:

Transference may be said to be an attempt of the patient to revive and re-enact, *in the analytic situation and in relation to the analyst*, situations and phantasies of his childhood. Hence transference is a regressive process. Transference develops *in consequence* of the conditions of the analytic experiment, viz., of the analytic situation and the analytic technique (*italics added*; p. 367).

Menninger (1958) limits transference to the analytic situation:

I define transference . . . as the unrealistic roles or identities unconsciously ascribed to a therapist by a patient in the regression of the psycho-analytic treatment and the patient's reactions to this representation derived from earlier experience (p. 81).

This interpretation, and others like it, are perhaps efforts at being 'operational'; but, if so, they overshoot the mark. To define transference in terms of the analytic situation is like defining microbes as little objects appearing under a microscope. The classic psycho-analytic position, exemplified by the writings of Freud, Fenichel, and Glover, though less pretentious, is more accurate. As the occurrence of bacteria is not limited to laboratories, so the occurrence of transference is not confined to the analytic situation; however, each is observed and studied best, not in its natural habitat, but under special circumstances.

This view does not imply that the analytic situation exerts no influence on the development of the transference. Of course it does. But so do

all other situations in which transferences play a part, such as the doctor-patient relationship, marriage, the work situation, and so forth. The analytic relationship differs from all others in two ways; first, it facilitates the development of relatively intense transference reactions in the patient; second, it is a situation in which transferences are supposed to be studied and learned from, not acted upon.

Transference and Transference Neurosis

The difference between transference and transference neurosis is one of degree. Analysts generally speak of transferences when referring to isolated ideas, affects, or patterns of conduct which the patient manifests towards the analyst and which are repetitions of similar experiences from the patient's childhood; and they speak of transference neurosis when referring to a more extensive and coherent set of transferences (Hoffer, 1956; Zetzel, 1956).

The imprecision in this usage stems from a lack of standards as regards the quantity of transferences required before one can legitimately speak of a transference neurosis. In other words, we deal here with a quantitative distinction, but possess neither measuring instruments nor standards of measurement for making quantitative estimates. Thus, the distinction between transference and transference neurosis remains arbitrary and impressionistic.

Transference as the Analyst's Judgement and as the Patient's Experience

Traditionally, transference has been treated as a concept formed by the analyst about some aspect of the patient's conduct. For example, the female patient's declarations of love for the male analyst may be interpreted as unrealistic and due to transference. In this usage, the term 'transference' refers to the analyst's judgement.

In addition, the word 'transference' is often used, and indeed should be used, to describe a certain kind of experience which the analytic patient has, and which people in certain other situations may also have. The analytic patient may feel—with or without being told so by the analyst—that his love of the therapist is exaggerated; or that this hatred of him is too intense; or that his anxiety about the therapist's health is unwarranted. In brief, the patient may be aware that the therapist is 'too important' to him. This phenomenon is what I mean by transference as experience and as self-judgement.

Although the experience of transference can

never be completely absent from analysis—if it were, how could it be analysed?—it has been curiously neglected in the theory of psycho-analytic treatment.

Fenichel (1941) mentions it, but fails to elaborate on it:

Not everything is transference that is experienced by a patient in the form of affects and impulses during the course of an analytic treatment. If the analysis appears to make no progress, the patient has, *in my opinion*, the right to be angry, and his anger need not be a transference from childhood—or rather, we will not succeed *in demonstrating* the transference component in it (*italics added*; p. 95).

The fact is that the analyst's judgement of whether or not the patient's behaviour is transference may be validated by the patient; and conversely, the patient's experience and self-judgement may be validated by the analyst. Let us review briefly what such a process of cross-validation might entail.

To repeat, our premise is that the term 'transference' expresses a judgement—formed either by the therapist or by the patient—about some aspects of the patient's behaviour. Thus, a patient's action or feeling may be judged as: (1) transference—if it is considered an expression of interest 'basically' directed towards childhood objects, deflected to the analyst or to other figures in the patient's current life; (2) reality-adapted behaviour—if it is considered a valid feeling about, or reaction to, the person towards whom it is directed.

Since the analytic situation involves two persons, and since each has a choice of two judgements about any particular occurrence, there will be four possible outcomes:

(a) Analyst and patient agree that the behaviour in question is transference. This allows the analyst to interpret the transference, and the patient to experience it and learn from it.

(b) The analyst considers the patient's behaviour transference, but the patient does not. Instances of so-called 'transference love' or 'erotized transference' are illustrative. Regardless of who is correct, analyst or patient, such disagreement precludes analysis of the transference. The commonest reasons for this impasse are: (i) that the analyst is mistaken in his judgement; (ii) that the patient, though exhibiting transference manifestations, is unaware of doing so.

(c) Analyst and patient agree that the patient's

behaviour is reality-oriented. This calls for no work that is specifically analytic. Needless to say, in this case as in all the others, both analyst and patient may be mistaken.

(d) The analyst may consider the patient's behaviour realistic, but the patient may know it is transference. This possibility, at least in this form, is rarely discussed in psycho-analysis. Consistent with its neglect, there are no formal examples—like 'transference love'—that could be cited to illustrate it. In general, the most common result is that the analyst 'acts out'. For example, he may engage in sexual acts with the patient, when in fact the patient was only testing him; or he may give up analysing—believing that the patient is too depressed, suicidal, or otherwise unanalysable—when, again, the patient was merely 'acting' difficult to test the analyst's perseverance in his efforts to analyse. This sort of occurrence cannot, of course, provide an opportunity for the analyst to make transference interpretations; it can, however, give the patient an opportunity to perform a piece of self-analysis, either during the analysis or, more often, afterwards.

The analysis outlined above helps to clarify the use of the word 'transference' in the treatment of so-called borderline or schizophrenic patients (Winnicott, 1956). In these cases, when analysts speak of transferences, they refer to constructions of their own which the patient does not share. On the contrary, to the patients, these experiences are invariably 'real'. The use of the term 'transference' in this context might be valid; but it is not valid to speak of 'analysing' such patients, because their so-called transferences can never be analysed (Szasz, 1957c).

Transference and Learning

The patient's task in analysis is to discriminate between two aspects of his relationships: those based on transferences, and those based on reality. In other words, the patient must learn to distinguish his reactions to the analyst as a symbol and as a real person. The analytic relationship, if properly conducted, affords a

particularly suitable—though not unique—situation for making this type of discrimination.

Phrased in terms of object relationships, we could say that the patient's task is to discriminate between the analyst as internal object and as external object. Internal objects can be dealt with only by intrapsychic defences; they can be tamed, but cannot be changed. To alter them, it is necessary to recognize the psychological existence of internal objects by their effects on actual, external objects. This can be accomplished only in the context of an actual human relationship. The analytic relationship—which allows the patient to invest the analyst with human qualities borrowed from others, but which the analyst neither accepts nor rejects, but only interprets—is thus designed to help the patient learn about his internal objects. This sort of psychotherapeutic learning must be distinguished from other learning experiences, such as suggestion or imitation. Only a theory based on the educational model can accommodate the role of transference in psycho-analytic treatment.

SUMMARY OF PART I

1. The terms 'transference' and 'reality' are evaluative judgements, not simple descriptions of patient behaviour.

2. Transferences occur in all human relationships. The analytic relationship differs from most others in (a) the ways in which it facilitates the development of transferences; and (b) the ways in which it deals with transferences.

3. The distinction between transference and transference neurosis is quantitative and arbitrary; there is no standard of the amount of transference required for a transference neurosis.

4. Human behaviour, especially in analysis, may be at once experienced and observed. Not only may the analyst consider the patient's behaviour either 'transference' or 'reality', but so may the patient himself. The analyst can interpret only what he recognizes as transference; the patient can learn only from what he experiences as and himself considers transference.

II. THE CONCEPT OF TRANSFERENCE AS A DEFENCE FOR THE ANALYST

In the first part of my paper I have reviewed the role of the concept of transference in the theory of psycho-analytic treatment. The aim of this second part is to demonstrate an unrecognized function of this concept: protecting the analyst from the impact of the patient's

personality. In psycho-analytic theory, the concept of transference serves as an explanatory hypothesis; whereas in the psycho-analytic situation, it serves as a defence for the analyst. (Its function for the patient will not be considered in this essay.)

*Types of Data in the
Psycho-analytic Situation*

It is often assumed, and sometimes stated, that the analyst's data are composed of the patient's verbal utterances and non-verbal behaviour. Not only is this view seriously over-simplified, but completely false.

To begin with, we must distinguish between two different types of data available to the analyst—observation and experience. This is a familiar distinction; we are accustomed to speaking of the analysand's ego as being split into two parts, one experiencing, the other observing. This double ego-orientation, however, is not specific for analysis; most adults with adequately developed personalities, unless intensely absorbed in an experience, are capable of assuming both a concrete and an abstract attitude towards their actions and experiences (Goldstein, 1951).

Even a solitary person, if self-reflective, has two classes of data about himself. First, his self-experience; for example: 'I feel anxious'. Second, his judgement of the experience: 'It is silly, there is nothing to be afraid of.'

In the analytic situation, the data—that is, who experiences, observes, and communicates what and to whom—are far more complex. The information available to the participants in a two-person situation may be arranged in a hierarchical fashion, as follows:

(i) Each participant's own experience. (This is sometimes called 'subjective experience', but the adjective is superfluous and misleading.)

(ii) Each participant's judgement of his experience; the observing ego takes its own experience as its object of study. For example: transference as an experience of the patient's, countertransference as an experience of the analyst's.

(iii) Each participant's judgement of his partner's experience. For example: the analyst's judgement that the patient's bodily experiences are hypochondriacal; or, the patient's judgement that the analyst's friendliness is a façade.

(iv) Each participant's reaction to the partner's judgement of his experience. For example: the patient's reaction to the analyst's view that the patient is suffering from hypochondriasis; or, the analyst's reaction to the patient's view that the analyst is the most understanding person in the world.

(v-n) Logically, one reaction may be superimposed on another, *ad infinitum*; in actuality,

we can experience and comprehend only a few back and forth movements in this sort of communicational situation.

Let us apply these considerations to the problem of transference in the practice of psycho-analysis. To start with the simplest example: the analyst decides that a certain behaviour by the patient is transference, and communicates this idea to him. The patient denies this, and claims that it is reality.

It is usually assumed that these two assertions contradict each other. Is this necessarily so? Only if each refers to the same object, occurrence, or relationship. This is the case when one person says, 'Boston is east of New York', and another says, 'No, Boston is west of New York'. In many other situations, however, where apparently contradictory statements are uttered, attention to detail reveals that the two speakers are not talking about the 'same thing'. For example, a hypochondriacal patient may say to his physician: 'I feel pains in my stomach'; the physician, having convinced himself that the patient is physically healthy, may counter with: 'No, you don't have any pains, you are just nervous'. These two people are talking about different things: the patient about his experiences, the physician about his medical judgement (Szasz, 1957a). Both statements may be true; both may also be false.

The point is that when the analyst communicates to the patient the idea that the latter has transferences, he is expressing a judgement; whereas when the patient denies this, he may be communicating one of two things: his experience, or his judgement of his experience. In the first instance, there is no contradiction between analyst and patient: they are not talking about the same thing. Only when the patient's denial refers to his own judgement of his allegedly transferenceal behaviour is there a contradiction between the assertions of the analyst and of the patient. But even then the two participants do not address themselves to and judge the 'same object': the analyst addresses himself to the patient's behaviour; whereas the patient addresses himself to (a) his own behaviour as experience, plus (b) his judgement of his own behaviour, plus (c) the analyst's interpretation of his behaviour as transference.

I think we are justified in concluding that the analytic situation is not a setting in which clearly formulated logical propositions are asserted, examined, and accepted as true or rejected as false. What may appear in the

analytic situation as logical contradiction may be resolved, by psychological and semantic analysis, into two or more non-contradictory propositions.

*Transference as Logical Construct
and as Psychological Defence*

We are now ready for the thesis of this essay—namely, that although in psycho-analytic theory the main function of the concept of transference is to serve as a logical construct, in the psycho-analytic situation it is to serve as a psychological defence for the analyst. In other words, in the context of psycho-analytical treatment, transference has a specific *situational significance*, which is lost in the setting of a psycho-analytic journal or book. What is this specific role which the concept of transference plays in the analytic situation?

To answer this question, we must try to recreate the psychological mood of the analytic situation. It is, of course, a very intimate situation: two people meet alone, frequently, and over a long period of time; the patient discloses his most closely guarded secrets; and the analyst pledges to keep his patient's confidences. All this tends to make the relationship a close one. In technical terms, we say that the analyst becomes a libidinal object for the patient. But what is there to prevent the patient from becoming a libidinal object for the analyst? Not much. Patients do indeed become libidinal objects for analysts, up to a point. But if this were all that there was to analysis, the analytic relationship would not differ from that between trusted physician and patient, or legal adviser and client. What distinguishes the analytic relationship from all others is that patient as well as analyst are expected to make their relationship to each other an object of scientific scrutiny. How can they do this?

It is not as difficult as it is often made to seem. To begin with, the expectation of scrutiny of self and other is made explicit: the patient learns that it is not enough to immerse himself in the therapeutic relationship, and wait to be cured—as he might wait to have a tooth extracted. On the contrary, he is told (if he does not already know) that he must use to their utmost his powers of observation, analysis, and judgement. The analyst must do the same. We know, however, that human beings are not automatic thinking machines. Our powers of observation and analysis depend not only on our mental abilities, but also on our emotional state: power-

ful emotions are incentives to action, not to contemplation. When in severe pain, we want relief, not understanding of the causes of pain; when lonely, we want human warmth, not explanations of the causes of our loneliness; when sexually desirous, we want gratification, not rejection of our advances with the explanation that they are 'transferences'.

The analytic situation is thus a paradox: it stimulates, and at the same time frustrates, the development of an intense human relationship. In a sense, analyst and patient tease each other. The analytic situation requires that each participant have strong experiences, and yet not act on them. Perhaps this is one of the reasons that not only many patients, but also many therapists, cannot stand it: they prefer to seek encounters that are less taxing emotionally, or that offer better opportunities for discharging affective tensions in action.

Given this experientially intense character of the analytic encounter, the question is, how can the analyst deal with it? What enables him to withstand, without acting out, the impact of the patient's powerful feelings for and against him, as well as his own feelings for and against the patient? The answer lies in three sets of factors:

1. The personality of the therapist: he must be ascetic to an extent, for he must be able to bind powerful affects, and refrain from acting where others might not be able to do so.

2. The formal setting of analysis: regularly scheduled appointments in a professional office, payment of fees for services rendered, the use of the couch, and so forth.

3. The concept of transference: the patient's powerful affects are directed not towards the analyst, but towards internal objects.

In this essay, I shall discuss only the last element. The concept of transference serves two separate analytic purposes: it is a crucial part of the patient's therapeutic experience, and a successful defensive measure to protect the analyst from too intense affective and real-life involvement with the patient. For the idea of transference implies denial and repudiation of the patient's *experience qua experience*; in its place is substituted the more manageable construct of a *transference experience* (Freud, 1914).

Thus, if the patient loves or hates the analyst, and if the analyst can view these attitudes as transferences, then, in effect, the analyst has convinced himself that the patient does not have these feelings and dispositions towards *him*.

The patient does not really love or hate the analyst, but some one else. What could be more reassuring? This is why so-called transference interpretations are so easily and so often misused; they provide a ready-made opportunity for putting the patient at arm's length.

Recognizing the phenomenon of transference, and creating the concept, was perhaps Freud's greatest single contribution. Without it, the psychotherapist could never have brought scientific detachment to a situation in which he participates as a person. There is historical evidence, which we shall review presently, to support the thesis that this could not be done before the recognition of transference; nor, apparently, can it be done today by those who make no use of this concept.

Not only may the analyst use the concept of transference as a defence against the impact of the patient's relationship with him (as person, not as symbol), but he may also use the concept of a reality relationship with the patient as a defence against the threat of the patient's transferences! We see this most often in analysts who treat borderline or schizophrenic patients. Indeed, the defensive use of the reality relationship has become one of the hallmarks of the Sullivanian modification of psycho-analysis. There are good reasons for this.

In the analysis of the normal-neurotic individual, one of the great dangers to the therapist is a *temptation*: the patient may appear too inviting as a person, as a sexual object, and so forth. To resist this, convincing himself that the patient is not interested in him as a real person is eminently useful. In the therapy of the schizophrenic, however, one of the great dangers is *compassion*: the patient has suffered so horribly as a child that to recollect it might be too painful, not only for him but for the therapist as well. To counteract this danger, then, the therapist must convince himself that what the patient needs is not a review of his past misfortunes, but a good relationship with the therapist. This might be true in some instances; in others, it might be an example of the defensive use of the concept of a reality relationship (Szasz, 1957c).

To recapitulate: I have tried to show that in the analytic situation the concepts of 'transference' and 'reality'—as judgements of the patient's behaviour—may both be used defensively, one against the other. This phenomenon is similar to the defensive function of affects, for example of pain and anxiety: each may be used

by the ego to protect itself from being overwhelmed by the other (Szasz, 1957a).

The Reactions of Breuer and Freud to Eroticism in the Therapeutic Situation

The cathartic method, which was the precursor of analytic technique, brought out into the open the hysterical patient's ideas and feelings about herself and her 'illness'. This, in turn, led to the recognition of the patient's sexual feelings and needs.

So long as hysterical symptoms were undisturbed—or were only chased after with hypnosis—patients were left free to express their personal problems through bodily signs and other indirect communications. Indeed, the medical, including psychiatric, attitudes toward such patients invited them to continue this type of communicative behaviour. Similarly, pre-Breuerian physicians were expected to respond to hysterical symptoms only in terms of their overt, common sense meanings: if a woman was neurasthenic, it was the physician's job to make her more energetic; if a man was impotent, he was to be made potent. Period. No other questions were to be asked. This state of affairs presented few problems to physicians (except that their therapeutic efficiency was low, but no lower than in organic diseases!), and led, of course, to no great changes in the patients. It was this *psychotherapeutically homeostatic situation between patients and doctors* which Breuer disturbed. He initiated the translation of the patient's hysterical body-language into ordinary speech (Szasz, 1961).

But Breuer soon discovered that this was not at all like deciphering Egyptian hieroglyphics. The marble tablet remained unaffected by the translator's efforts, but the hysterical patient did not. Thus, as Breuer proceeded in translating Anna O.'s symptoms into the language of personal problems, he found it necessary to carry on a relationship with her without the protection previously afforded by the hysterical symptoms. For we ought not forget that the defences inherent in the hysterical symptoms (and in others as well) served not only the needs of the patient, but also of the physician. So long as the patient was unaware of disturbing affects and needs—especially aggressive and erotic—she could not openly disturb her physician with them. But once these inhibitions were lifted—or, as we might say, once the translation was effected—it became necessary for the therapist to deal with the new situation: a sexually

aroused attractive *woman*, rather than a pitifully disabled *patient*.

Breuer, as we know, could not cope with this new situation, and fled from it. Freud, however, could, and thereby established his just claim to scientific greatness.

My foregoing comments are based on the many historical sources of the origins of psychoanalysis made available to us, especially in the past decade. Instead of citing specific facts, most of which are familiar to analysts, I shall quote some passages from Jones's (1953) biography of Freud, which illustrate how the need for transference as a defence for the therapist arose, and the function it served for Breuer and Freud.

'Freud has related to me a fuller account than he described in his writing of the peculiar circumstances surrounding the end of this novel treatment. It would seem that Breuer had developed what we should nowadays call a strong counter-transference to his interesting patient. At all events he was so engrossed that his wife became bored at listening to no other topic, and before long jealous. She did not display this openly, but became unhappy and morose. It was a long time before Breuer, with his thoughts elsewhere, divined the meaning of her state of mind. It provoked a violent reaction in him, perhaps compounded of love and guilt, and he decided to bring the treatment to an end. He announced this to Anna O., who was by now much better, and bade her good-bye. But that evening he was fetched back to find her in a greatly excited state, apparently as ill as ever. The patient, who according to him had appeared to be an asexual being and had never made any allusion to such a forbidden topic throughout the treatment, was now in the throes of an hysterical childbirth (pseudocyesis), the logical termination of a phantom pregnancy that had been invisibly developing in response to Breuer's ministrations. Though profoundly shocked, he managed to calm her down by hypnotizing her, and then fled the house in a cold sweat. The next day he and his wife left for Venice to spend a second honeymoon, which resulted in the conception of a daughter; the girl born in these circumstances was nearly sixty years later to commit suicide in New York.

'Confirmation of this account may be found in a contemporary letter Freud wrote to Martha, which contains substantially the same story. She at once identified herself with Breuer's wife, and hoped the same thing would not ever happen to her, whereupon Freud reproved her vanity in supposing that other women would fall in love with *her* husband: "for that to happen one has to be a Breuer."

'The poor patient did not fare so well as one might gather from Breuer's published account. Relapses took place, and she was removed to an

institution in Gross Enzerdorf. A year after discontinuing the treatment, Breuer confided to Freud that she was quite unhinged and that he wished she would die and so be released from her suffering. She improved, however, and gave up morphia. A few years later Martha relates how "Anna O.," who happened to be an old friend of hers and later a connection by marriage, visited her more than once. She was then pretty well in the daytime, but still suffered from her hallucinatory states as evening grew on.

'Frä. Bertha (Anna O.) was not only highly intelligent, but extremely attractive in physique and personality; when removed to the sanatorium she inflamed the heart of the psychiatrist in charge. Her mother, who was somewhat of a dragon, came from Frankfurt and took her daughter back there for good at the end of the eighties. Bertha, who was born and brought up in Vienna, retained her Viennese grace, charm and humour. Some years before she died she composed five witty obituary notices of herself for different periodicals. A very serious side, however, developed when she was thirty, and she became the first social worker in Germany, one of the first in the world. She founded a periodical and several institutes where she trained students. A major part of her life's work was given to women's casues and emancipation, but work for children also ranked high. Among her exploits were several expeditions to Russia, Poland, and Roumania to rescue children whose parents had perished in pogroms. She never married, and she remained very devoted to God.

'Some ten years later, at a time when Breuer and Freud were studying cases together, Breuer called him into consultation over an hysterical patient. Before seeing her he described her symptoms, whereupon Freud pointed out that they were typical products of a phantasy pregnancy. The recurrency of the old situation was too much for Breuer. Without saying a word he took up his hat and stick and hurriedly left the house' (pp. 224-226).

I should like to underscore the following items in this account:

1. Having effected the translation from hysterical symptom directed impersonally to anyone, to sexual interest directed to the person of Breuer himself, Breuer panicked and fled. The relationship evidently became too intense for him.

2. Breuer protected himself from the danger of this relationship—that is, from his anxiety lest he succumb to Anna O.'s charms—first, by literally fleeing into the arms of his wife; and later, by convincing himself that his patient was 'very sick', and would be better off dead!

3. Freud, to whom Anna O.'s problem was essentially a theoretical one—he had no personal,

therapeutic relationship with her—dealt with the threat of a too intense involvement with female patients by convincing himself that this could happen only to Breuer. I shall comment on this later.

Let us now take a look at the events preceding the publication of *Studies on Hysteria* (1893–95).

In the late eighties, and still more in the early nineties, Freud kept trying to revive Breuer's interest in the problem of hysteria or to induce him at least to give to the world the discovery his patient, Frl. Anna O., had made. In this endeavour he met with a strong resistance, the reason for which he could not at first understand. Although Breuer was much his senior in rank, and fourteen years older, it was the younger man who—for the first time—was entirely taking the leading part. It gradually dawned on Freud that Breuer's reluctance was connected with his disturbing experience with Frl. Anna O. related earlier in this chapter. So Freud told him of his own experience with a female patient suddenly flinging her arms around his neck in a transport of affection, and he explained to him his reasons for regarding such untoward occurrences as part of the transference phenomena characteristic of certain types of hysteria. This seems to have had a calming effect on Breuer, who evidently had taken his own experience of the kind more personally and perhaps even reproached himself for indiscretion in the handling of his patient. At all events Freud ultimately secured Breuer's cooperation, it being understood that the theme of sexuality was to be kept in the background. Freud's remark had evidently made a deep impression, since when they were preparing *Studies* together, Breuer said apropos of the transference phenomenon, "I believe that is the most important thing we both have to make known to the world" (Jones, 1953, p. 250).

In this account, the following facts deserve emphasis:

(i) The psychotherapeutic material on which Freud discovered transference concerned not his own patient, but someone else's: the experiences were Anna O.'s and Breuer's, the observations Freud's.

(ii) A heavy thread of denial runs through Freud's thinking in formulating the concept of transference; for example: for it to happen, '... one has to be a Breuer'; when he found that one does not, he concluded that the patient's love transference is due to the nature of the hysterical illness—under no circumstances must the patient's attraction to the therapist be considered 'genuine'.

(iii) Freud's concept of transference was vastly reassuring to Breuer.

We shall examine each of these topics in greater detail.

Transference as a Defence for the Analyst

Anna O., Breuer, and Freud

The fact that Anna O. was not Freud's patient has, I think, not received the attention it deserves. Possibly, this was no lucky accident, but a necessary condition for the discovery of the basic insights of psycho-analysis. In other words, the sort of triangular situation which existed between Anna O., Breuer, and Freud may have been indispensable for effecting the original break-through for dealing scientifically with certain kinds of highly charged emotional materials; once this obstacle was hurdled, the outside observer could be dispensed with.

It seems highly probable that Freud's position *vis-à-vis* both Breuer and Anna O. helped him assume a contemplative, scientific attitude towards their relationship. Breuer was an older, revered colleague and friend, and Freud identified with him. He was thus in an ideal position to empathize with Breuer's feelings and thoughts about the treatment of Anna O. On the other hand, Freud had no significant relationship with Anna O. He thus had access to the kind of affective material (from Breuer), which had been unavailable to scientific observers until then; at the same time, he was able to maintain a scientific attitude towards the data (which impinged upon him only by proxy).

It is sometimes said that the psycho-analytic method was discovered by Anna O. Actually, she discovered only the cathartic method and—as it turned out—its limited therapeutic usefulness. She was, however, a truly important collaborator in a more important discovery: the concept of transference. This concept is the cornerstone of psycho-analytic method as well as theory, and was created through the delicate collaboration of three people—Anna O., Breuer, and Freud. Anna O. possessed the relevant basic facts; Breuer transformed them into usable scientific observations, first by responding to them in a personal way, and second by reporting them to Freud; Freud was the observer and theoretician.

Subsequently, Freud succeeded in uniting the latter two functions in himself. In his self-analysis, he was even able to supply all three roles from within the riches of his own personality. It is unfortunate that Freud's self-analysis is sometimes regarded as a uniquely heroic achievement. To be sure, he might have been

the first person ever to perform this sort of work (although one cannot be sure of this); he was certainly the first to describe and thus make public the methods he used. The discovery of Newton's laws and the principles of calculus were also heroic achievements; this does not prevent us from expecting high school students to master them and, indeed, to go beyond them. There is no reason to treat psycho-analysis differently.

To repeat: I have tried to show that because Anna O. was not Freud's patient it was easier for him to assume an observing role toward her sexual communications than if they had been directed towards himself.

Denial and Transference

Let us now examine Freud's attempt to reassure his fiancée, by writing her that female patients could fall in love 'only with a Breuer', never with him.

Freud may have believed this to be true; or if not, he may have thought it would reassure Martha; or, he may have toyed with both possibilities, believing now one, now the other. The evidence for the probability of each of these hypotheses, though only suggestive, is worth pondering.

We must start with a contradiction: Freud asserted that female hysterical patients have a 'natural' tendency to form love transferences towards their male therapists; if so, one surely does not have to be a Breuer for this to happen. But then why did he write to Martha as he did?

We can only guess. Perhaps it was, as already mentioned, merely a device to reassure his fiancée. He might have done this, however, more effectively by explaining his concept of transference to her; it was, as we know, very reassuring to Breuer. There may have been two reasons why he did not do this. First, his concept of transference was perhaps not as clearly formulated when he wrote to Martha in 1883, as when he used it on Breuer nearly ten years later. Second, Freud was under the influence of a powerful, positive father transference to Breuer. From this point of view, Freud's assertion that women fall in love 'only with a Breuer' assumes new importance. It means that Breuer is the father, Freud the son. Thus, his statement to Martha would mean that women fall in love only with fathers (adult males), not with children (immature boys).

I mention these things, not to analyse Freud, but to cast light on the function of the concept

of transference for the analyst. Freud's self-concept during the early days of psycho-analysis is relevant to our understanding of the work-task of the analyst. His self-deprecating remark is appropriate to the reconstruction offered above of the triangular relationship of Anna O., Breuer, and Freud. It seems that Freud had divided certain activities and roles between Breuer and himself: Breuer is the 'father', the active therapist, the heterosexually active male; Freud is the 'son', the onlooker or observer, the sexually inactive child. This, let us not forget, was the proper social-sexual role of the middle-class adolescent and young adult in the Vienna of the 1880s: aware of sexual desire, he was expected to master it by understanding, waiting, working, and so forth. The same type of mastery—not only of sexual tensions, but of all other kinds that may arise in the analytic situation—must be achieved by the analyst in his daily work.

When Freud was young—and presumably sexually most able and most frustrated—it may have been easier for him to believe that sexual activity with his female patients was impossible, than that it was possible but forbidden. After all, what is impossible does not have to be prohibited. A saving of defensive effort may thus be achieved by defining as impossible what is in fact possible.

Denial plays another role in the concept of transference. For, in developing this concept, Freud denied, and at the same time reaffirmed, the reality of the patient's experience. This paradox, which was discussed before, derives from the distinction between experience and judgement. To deny what the patient felt or said was not new in psychiatry; Freud carried on this tradition, but gave it a new twist.

According to traditional psychiatric opinion, when a patient asserts that he is Jesus Christ, the psychiatrist ought to consider this a delusion. In other words, what the patient says is treated as a logical proposition about the physical world; this proposition the psychiatrist brands as false. Psychiatrists and non-psychiatrists alike, however, have long been aware that the patient may, indeed, feel as though he were Jesus Christ, or be convinced that he is the Saviour; and they may agree with the fundamental distinction between affective experiences about the self, and logical propositions about the external world. The epistemological aspects of this problem, and their relevance to psychiatry, were discussed elsewhere (Szasz, 1961; and Part

I of this paper). What is important to us now is to recognize that, in the concept of transference, Freud introduced this fundamental distinction into psychiatry, without, however, clarifying the epistemological foundation of the concept.

Thus, when Freud introduced the concept of transference into psychiatry, he did not deny the patient's self-experience: if the patient declares that she is in love with the analyst, so be it. He emphatically repudiated, however, the action-implication of the experience: the patient's 'love' must be neither gratified nor spurned. In the analytic situation, both of these common-sense actions are misplaced; in their stead Freud offered 'analysis' (Freud, 1914). He thus took what modern philosophers have come to describe as a *meta position* toward the subject before him (Reichenbach, 1947).

Transference and Reassurance

The notion of transference is reassuring to therapists precisely because it implies a denial (or mitigation) of the 'personal' in the analytic situation. When Freud explained transference to Breuer, Breuer drew from it the idea that Anna O.'s sexual overtures were 'really' meant for others, not for him: he was merely a symbolic substitute for the patient's 'real' love objects. This interpretation reassured Breuer so much that he dropped his objections to publishing *Studies on Hysteria*.

The concept of transference was needed by Freud, no less than by Breuer, before either dared publish the sort of medico-psychological material never before presented by respectable scientists. The reaction of many medical groups confirmed Breuer's fears: this type of work was a matter for the police, not for doctors. More than just the prudery of German medical circles of the late nineteenth century is betrayed by this view; it suggests that, in psycho-analysis, what stands between obscenity and science is the concept of transference. This concept, and all it implies, renders the physician a non-participant with the patient in the latter's preoccupation with primary emotions (such as eroticism, aggression, etc.). Only by not responding to the patient on his own level of discourse and instead analysing his productions, does the analyst raise his relationship with the patient to a higher level of experience. Unable to comprehend the meaning of transference, Freud's early critics could not distinguish analytic work from indecent behaviour.

The concept of transference was reassuring for

another reason as well. It introduced into medicine and psychology the notion of the *therapist as symbol*: this renders the *therapist as person* essentially invulnerable.

When an object becomes a symbol (of another object) people no longer react to it as an object; hence, its features *qua* object become inscrutable. Consider the flag as the symbol of a nation. It may be defiled, captured by the enemy, even destroyed; national identity, which the flag symbolizes, lives on nevertheless.

The concept of transference performs a similar function: the analyst is only a symbol (therapist), for the object he represents (internal imago). If, however, the therapist is accepted as symbol—say, of the father—his specific individuality becomes inconsequential. As the flag, despite what happens to it, remains a symbol of the nation, so the analyst, regardless of what he does, remains a symbol of the father to the patient. Herein lies the danger. Just as the pre-Freudian physician was ineffective partly because he remained a fully 'real' person, so the psycho-analyst may be ineffective if he remains a fully 'symbolic' object. The analytic situation requires the therapist to function as both, and the patient to perceive him as both. Without these conditions, 'analysis' cannot take place.

The use of the concept of transference in psychotherapy thus led to two different results. On the one hand, it enabled the analyst to work where he could not otherwise have worked; on the other, it exposed him to the danger of being 'wrong' *vis-à-vis* his patient—and of abusing the analytic relationship—without anyone being able to demonstrate this to him.

If we agree that there is such an inherent error in psycho-analysis—and it is hard to see how anyone could dispute this today—it behoves us to try to correct it. Of course, there have been many suggestions, beginning with Freud's proposal that analysts should undergo a personal analysis, and ending with the current emphasis on so-called high standards in analytic institutes. All this is futile. No one, psycho-analysts included, has as yet discovered a method to make people behave with integrity when no one is watching. Yet this is the kind of integrity that analytic work requires of the analyst.

SUMMARY OF PART II

My aim in this part of my essay has been to develop the thesis that the concept of transference fulfils a dual function: it is a logical

construct for the psycho-analytic theoretician, and a psychological defence for the psycho-analytic therapist. To illustrate and support this thesis, the historical origins of the concept were re-examined. Breuer, it appears, was overcome by the 'reality' of his relationship with Anna O. The threat of the patient's eroticism was effectively tamed by Freud when he created the concept of transference: the analyst could henceforth tell himself that he was not the genuine object, but a mere symbol, of his patient's desire.

Transference is the pivot upon which the entire structure of psycho-analytic treatment

rests. It is an inspired and indispensable concept; yet it also harbours the seeds, not only of its own destruction, but of the destruction of psycho-analysis itself. Why? Because it tends to place the person of the analyst beyond the reality testing of patients, colleagues, and self. This hazard must be frankly recognized. Neither professionalization, nor the 'raising of standards', nor coerced training analyses can protect us from this danger. Only the integrity of the analyst and of the analytic situation can safeguard from extinction the unique dialogue between analysand and analyst.

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THE PLURALITY OF DETERMINANTS IN PSYCHO-ANALYSIS¹

By

ISHAK RAMZY, TOPEKA

Ever since Freud started to announce his findings concerning the human mind, almost nothing of his views has been left uncontested. When he asserted the importance of the unconscious, he was criticized for his neglect of the conscious; when he emphasized the role of sexuality, he was accused of having reduced everything to pleasure and eroticism. If he talked instinct, he was asked what about environment; when he talked biology, he was asked about sociology; and when he underlined childhood traumata and neurosis, he was asked what about the stress of life in adulthood, physical, emotional, and economic.

This was the main line of argument used against psycho-analysis, not only by its critics and adversaries, but often also by some of its own followers. The old arguments have not stopped. Still psycho-analysis is accused of being a narrow outlook which does not take into consideration much of that which enters into the fabric of human beings. Strangely enough, most of the contemporary attacks against psycho-analysis are being hurled by its own people. However, it is often the case that the newer attempts, like the older ones, are mainly sustained by the wilful or inadvertent neglect to recognize one or the other of the few fundamental postulates of this discipline.

Probably no one is to blame for the old controversies or the new more than Freud himself. Beyond the historical and human factors which may have led to the controversies and the disputes, and beyond Freud's aversion to answering criticisms, the motives of which he knew only too well, he adopted toward the other disciplines overlapping psycho-analysis a haughty attitude of lofty indifference, which was mimicked by some of his followers as defensive avoidance. All this, together with Freud's wish to control his speculative interests and to concentrate on the empirical investigation of mental phenomena,

led to an important lack in the psycho-analytic library.

The most important tenet of psycho-analysis is perhaps that of determinism. This principle, as remarkably simple as scientific method itself, contains the one intellectual stand that is essential for the psycho-analyst in his theoretical considerations or therapeutic attempts. However, it may be the one concept, the neglect of which has been responsible for many of the errors analysts and non-analysts alike are liable to commit. The frequent usage of such a term as 'overdetermination'—a 'pleonasm', or redundant term, as grammar and rhetoric would certainly judge it—only shows how vague the concept is in psycho-analytic literature.

To proceed rather systematically, it may be better to define what is meant by determinism, though at the risk of mentioning a few truisms. In ancient and scholastic modes of thinking, it was believed that there must be some order in the universe. Nature was considered to be arranged according to the principle of uniformity, or the principle of causality. Many thinkers, whether they were philosophers or theologians, thus toiled to discover the causes of things. Their conclusions were coloured, of course, by the prevalent beliefs and the stage of human progress achieved.

It was David Hume (1711–1776) who dealt a fatal blow at the metaphysical concept of causality. He developed to its logical conclusion the empirical philosophy of the English school. In his *Treatise of Human Nature* (1739), he dealt with the understanding, the passions, and the morals, each in a separate book. In an important section of the first book, Hume dealt with 'Knowledge and Probability'. There he discussed the seven kinds of relation; namely, resemblance, identity, relation of time and place, proportion in quantity or number, degree in any quality, contrariety, and causation. In relation

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to causation, he refuted the scholastic and the Cartesian view that it was a necessary logical connexion. Hume asserted that when we say A causes B, we mean only that A and B have been constantly connected in our experience, not that there is some necessary connexion between them as such. 'We have no other notion of cause and effect but that of certain objects which have been always conjoined together. We cannot penetrate into the reason of the conjunction.'

The concept of causality as mere correlation was definitely formulated by J. S. Mill (1806-1873) as the fundamental principle of induction. Modern thought owes to Mill for his inductive logic as much as, or more than, it owes to Aristotle for his deductive logic. Parenthetically, Freud translated into German one of Mill's works, and it is probable that he was familiar with Mill's *magnum opus*, *System of Logic* (1843).

The new version of causality soon became a central concept of modern science, which started to adopt other terms, such as 'law' and 'determinism'. Thus the principle of induction became that of determinism, a version well enunciated by the French logician Goblot (1925), who says: 'Induction supposes a double principle: (1) The order of nature is constant, and laws have no exception; (2) the order of nature is universal, and there are no effects nor details of effects which are not regulated by laws. This double principle is determinism.' Helmholtz, again, whose effect on Freud has been traced, wrote: 'The principle of causality is nothing else than the assumption that all phenomena of nature are governed by laws' (Bernfeld, 1944).

Determinism from the nineteenth century on became one of the essential components of the scientific spirit. We owe it to Claude Bernard that he made explicit that the principle of all science is 'determination of phenomena, which is as absolute in the phenomena of living matter as it is in those of inert matter' (Bernard, 1865).

As it stands hitherto, it would be incorrect to equate determinism with fatalism and to mean by this the doctrine according to which certain events are fixed in advance by an external power higher than the will, in such a way that whatever a person may do, they will unavoidably happen. In this sense it is called sometimes 'external determinism', in contrast to 'internal determinism'. But determinism can correctly convey the three following meanings: First, in the concrete sense, it means all the conditions necessary to bring about a certain phenomenon; second, in

the abstract sense, the characteristic of a series of events in which every determinant depends on the others in such a way that it can be predicted, produced, or prevented for certain, according to what is non-produced or non-prevented; and third, a philosophical doctrine according to which all the events of the universe, and especially human acts, are linked in such a way that things being what they are at any given moment in time, there will be at any previous or following moment but one, only, state which is compatible with the first (Lalande, 1947).

Such is the clear consensus about determinism of logicians and philosophers of science whose work on this concept has included important discussions of some side problems connected with it, such as probability, hazard, and free will. In recent years a little headache, though, has started to centre around the role of indeterminism in nature, but most of it has been finally relieved (Northrop, 1948).

In any consideration of determinism there looms large a very important point which was discussed convincingly in a whole chapter in Book III of Mill's *System of Logic* (1843) under the heading, 'Of Plurality of Causes, and of the Intermixture of Effects'. There Mill states: 'It is not true, then, that one effect must be connected with only one cause, or assemblage of conditions, that each phenomenon can be produced in only one way. There are often several independent modes in which the same phenomenon could have originated. One fact may be the consequent in several invariable sequences; it may follow, with equal uniformity, any one of several antecedents, or collections of antecedents. Many causes may produce mechanical motion; many causes may produce some kinds of sensation; many causes may produce death. A given effect may really be produced by a certain cause, and yet be perfectly capable of being produced without it.'

With still more recent work in applied logic, on the theory of statistics, and in the philosophy of science, the concept of determinism was further clarified and more sharply defined. In the course of more recent work the corpse of causality was subjected to further humiliation. No less than a Bertrand Russell has said, 'The law of causality, I believe, like much that passes muster among philosophers, is a relic of bygone age, surviving, like monarchy, only because it is erroneously supposed to do no harm.' With the usage of such notions as that of sequence, approximation, probability, and function, the

concept of determinism came to be defined not even in terms of the same 'effect' just following the same 'cause', but in terms of the sameness of relations. 'And even sameness of relations', says Russell, 'is too simple a phrase. It is impossible to state this accurately in non-mathematical language; the nearest approach would be as follows: "There is a constant relation between the state of the universe at any instant and the rate of change in the rate at which any part of the universe is changing at that instant, and this relation is many—one, i.e., such that the rate of change in the rate of change is determined when the state of the universe is given".' Or it may perhaps be easier to grasp Russell's formula than his verbal definition of determinism: 'A system is said to be "deterministic" when, given certain data, $e_1, e_2 \dots e_n$, at times $t_1, t_2 \dots t_n$, respectively, concerning this system, if E_t is the state of the system at any time t , there is a functional relation of the form

$$E_t = F(e_1, t_1, e_2, t_2 \dots e_n, t_n, t).$$

It is important to note that Russell in his elaboration of the formula goes on to say: 'It is to be observed that a system which has one set of determinants will in general have many' (Russell, 1918).

Whatever views one may enumerate, none of them has neglected or minimized the importance of the 'plurality of causes'. Feigl, who does not see any need to reject the ordinary terms 'cause' and 'effect' if proper caution is employed in their application, emphasizes that 'we must remember that it is an entire set of conditions that represents "the" cause of an event' (Feigl and Brodbeck, 1953).

It is obvious that the more complex a phenomenon is, the more complex its causes must be; thus, a phenomenon of the mind is more complex than a phenomenon of life, and this is more so than one on the physical level of existence. A task of each scientist in his field becomes more difficult in proportion to the complexity of the phenomena he deals with, but all scientists—though in different degrees—have to contend with the plurality of causes which determine any one single event in the universe of their discourse. The more a discipline advances, the more it becomes possible to assess the different magnitudes of the causes, to ignore some and concentrate on others, but never to reach a stage where the relation of cause to effect is a matter of one-one except as reductions and abstractions. It is here, perhaps, that lies the reason why

psycho-analysis extends that long. Regression—in this context—is the only way which leads back in time when causes were not only much fewer, but also of a more compelling and unavoidable effect on the infant.

There is no reason to assume that such an understanding of determinism was not that of Freud. He was a well-educated man who most probably had direct access to many of the views mentioned earlier (Ramzy, 1956), and he demonstrated through his voluminous works what a grip he had not only on formal, but also on applied logic.

If for topical reasons or in the ecstasy of making a new discovery he gave the impression that he singled out the impact of any one or the other factor on the human mind, this has to be taken only as a matter of style and economy, not as a renunciation of that integral aspect of determinism; namely, that of multiple causality. Even in his single-purposed book *Three Essays on Sexuality* (1905) he says, for example: 'What appears to be the strong tendency . . . of psycho-neurotics to perversion may be *collaterally determined*, and must in any case be *collaterally intensified*. The fact is that we must put sexual repression as an internal factor alongside such external factors as limitation of freedom, inaccessibility of a normal sexual object, the dangers of the normal sexual act, etc., which bring about perversions in persons who might perhaps otherwise have remained normal.' (Italics mine.)

In his *magnum opus*, Freud emphasized 'overdetermination' in dreams in not less than some twenty passages. To quote him only once or twice from *The Interpretation of Dreams* (1900), he said, while dealing with 'the dream of the botanical monograph': 'Thus "botanical" was a regular nodal point in the dream. Numerous trains of thought converged upon it, which, as I can guarantee, had appropriately entered into the context of the conversation with Dr. Königstein. Here we find ourselves in a factory of thoughts where, as in the "weaver's masterpiece" (and then he quotes from Goethe's *Faust*)—

" . . . a thousand threads one treadle throws
Where fly the shuttles hither and thither,
Unseen the threads are knit together,
And an infinite combination grows."

Lower on the same page, he goes on to say, 'The explanation of this fundamental fact can also be put in another way: each of the elements

of the dream's content turns out to have been "overdetermined". In another place he says also: '... from the nature of things, it seems clear that the two factors of multiple determination and inherent psychical value must necessarily operate in the same sense.'

In various other papers (1912, 1913) Freud hammers in the principle of multiple causality; but the trouble with Freud's statements concerning scientific principles is that they often were mentioned by implication, and whenever explicit they were put in very simple, ordinary words, which would not command the awe a scientific law requires. As just another example of this, one can mention the term, also probably coined by Freud himself, to label matters of causation in mental illness. This is the familiar term 'complementary' or 'complemental series', which he particularly spelled out in the *Introductory Lectures* (1917), and where he says that in the aetiology of the neurosis, cases fall into a series where at one end of it 'there are people who would have fallen ill whatever happened, whatever their experiences, however merciful life had been to them, because of their anomalous libido development. At the other end stand cases which call forth the opposite verdict. They would undoubtedly have escaped illness if life had not put such and such burdens upon them.'

From Freud on, the principle of multiple causation was apparently so much taken for granted that the very few contributions (Hartmann, 1959; Knight, 1946; Waelder, 1936) dealing closely with that concept came out either topical or tangential. Yet this has always been the very principle which guides every analyst in his work. To mention just one facet of the strict adherence to it, it is the rule before recommending psycho-analytic treatment, not only to assess the various mental factors, but also to take into account the physical, the economic, the social, and sometimes even the political factors which touch upon the patient's life.

However, because of the strictures of psycho-analytic technique, the belief in the plurality of causes has comparatively very limited clinical evidence to sustain it. The psycho-analyst, in adherence to the rules of technique, confines himself in helping any one of his patients to treating him as if he were a unit unto himself, and as if he were just a psyche existing by itself. The analyst gains access to the deeper layers of just this one mind, and thus has direct evidence

concerning only his own patient's impulses, traumata, joys, and sorrows—and in fact concerning this one mind only in the here and now of the analytic situation; i.e., within the transference. Any other inference, however accessible or evident it may be, connected with the past or with other persons or events in the patient's life, is at best indirect and of the second order. When it happens that two members of the same family are in analysis with two analysts who know each other, it is also the wise custom for these two analysts not to exchange information about their respective patients.

Even if the analysts collate their findings during or after the treatment has terminated, it will still be, methodologically speaking, the observations of two phenomena by two different observers, each of whom has his own personal equations and his different degrees and ways of intervention in the phenomenon. In short, logically speaking, nothing provides more evidence than the study, by the same analyst, of more than one mind which have come to influence each other, such as that of mother and child, husband and wife, etc.

With the exception of some two or three authors (Ackerman, 1958; Mittelman, 1944; Oberndorf, 1938), who for that matter confined their contributions to generalities, the consensus of psycho-analysts is that it is unwise for any one analyst to undertake concurrently the treatment of any intimately related couple (Kubie, 1956). On the other hand, the consecutive treatment is extremely unpractical if therapeutically feasible. Such a situation led to the result that there are not as yet—to my knowledge—any available published clinical data (Ramzy, 1953) to demonstrate the principle of multiple determination on that methodological level.

Case Material

It happened once in my experience that circumstances willed that I undertake the analysis of a husband and his wife successively. Only a few of the salient features of the analyses of these two cases will be presented in illustration of the aforementioned considerations. Many years ago a man in his late 40s, but looking much younger, came to me for analysis. In an obviously challenging attitude, he told me some of his complaints, for which physical medicine had been of no avail. It was evident that he was one of those people who have long been used to ordering others around, that he was alert, precise, and demanding.

For many years he had been suffering from vague, intractable pains in the digestive system, and had a long record of various medical and surgical attempts, with many specialists, in more than one country. In spite of all this, his work capacity, his love of sport, and his general physical stamina were examples one can seldom meet or hear of. For instance, he would drive some 200 miles after a full day's work, then stay up to the small hours of the morning discussing more work and making merry. With the sunrise he would pilot a plane to where he would inspect one or the other of his business concerns, fly back where he left his car, to drive again in the scorching heat of the Mediterranean summer afternoon, have a good game of tennis, and then turn up looking alert and fresh for his analytic hour.

He was evidently a very intelligent man, with a sharp sense of humour. He mastered his profession, was very well read, had many social contacts, and travelled a great deal. He had a good understanding of people, but he would fly at times into uncontrollable outbursts of rage, and then become very abusive and merciless. Though well off, he was careful about his money to the extent of meanness. He came from a distinguished family, whose members were well known in various walks of public life. The father was known to have been rather despotic, cruel, and promiscuous. The patient was the eldest of his siblings. The mother died after the birth of the second boy, probably from puerperal fever. Care of the infants was relegated to several nannies, who were frequently changed. There was, however, a maternal grandmother, who showered the two little infants with her affection and kindness during the infrequent visits to her the father allowed them. The father married his second wife when the patient was some five years of age. His school years were rather uneventful, except for the fact that he was one of the outstanding handful of boys in secondary school whom the headmaster had chosen to take under his wing for guidance and further private care during the turbulent years of adolescence. The patient fared well at the university, and did postgraduate work abroad, where he got married. Back in his own country his abilities were soon recognized, and he quickly climbed up to a very successful career.

Early in the analysis, among many recollections and screen-memories, he mentioned that his 'first sexual experience' took place at the age of eight years, when he tried to touch the buttocks

of a girl. This led him directly to remember the excitement he felt towards his stepmother around that age, and he hastened to say that she was not a blood relative, and so one could not consider her taboo for him.

Some time later it struck him that he had been using the word 'nurse' to refer to the rigid and puritan English governess who stayed with them for a few years. Then he gave an account of his father's cruelty and his daily morning thrashings, which went on until the patient was nine or ten. Every morning the two brothers were summoned to greet the father. The father would look at their faces, and finding them pale would assume that they had been masturbating, though their hands had been tied up during the night. Whenever possible, his brother would follow the advice of the governess to pinch and rub his own cheeks to bring some colour into them, and thus save himself the beating, whereas the patient would not do that. This was, he said, against his principles; he would rather face his lot than be deceitful.

His first dream was about touching the rear of a woman. During the same hour, he went on to talk about his fits of depression, self-pity, and feelings of imminent death, most of which occurred around a certain time of the year. This he suspected was linked with his mother's death, about which he had an oft-mentioned screen-memory. Filling in more details about his life history, the patient recalled that he was kept dressed in girls' attire, with his hair long and curly, up to the time he was to join the primary school, where he and his brother were not to go unless escorted, on the short way, by the father's footman. He also gave a detailed account of sexual experiences with a large variety of maids, mostly of an anal nature.

As analysis continued, physical symptoms became more acute, especially at weekends, when he complained of burning pain in the stomach, of colics, constipation, and fatigue. Very conspicuous was his choice of words and the figures of speech used, together with a repeated complaint about the meanness of his father, who used to have, according to many living members of the family, endless bickerings with the grandmother over the cost of milk for the two little orphans. In a session when there was much material about the digestive system, that problem of milk, interest in girls' buttocks, together with an account about an outburst of rage at people whom he takes in his arms, protects, or—literally translated—'embraces',

and who then let him down, he was told a transference interpretation, followed by a content one. The very next day he reported that he was feeling much better emotionally and physically. Then he recalled how his grandmother used to say, referring to his mother, that she was still here, tapping on his stomach and using the same gesture he used when he located his pain. A day later, he went to see his internist and told him that he thought his complaints were functional and that he was feeling all right, an idea the internist welcomed, apparently relieved from such an exacting patient.

By then scores of hours had passed without his ever mentioning his wife or anything connected with her. When he started to speak of his marital relationships, he said that he avoided any physical contact with his wife, though he still loved and adored her. In the beginning it was a fully integrated love, he said, but now he would rather have a nocturnal emission or masturbate than come near her, though he did not want to hurt her feelings. For him 'she was everything, a sister, a daughter, and the mother' he could not remember. He complained of his wife's infantile uterus, his inability to penetrate, and said that contacts had stopped completely between them, even his anal practices, which were a hangover from his early homosexual habits. 'It is now a strong attachment and a spiritual love.' He also said that he did not care for children, only sometimes he would have liked to have had offspring for her sake. He mentioned in this connexion that the highest pitch in his fits of depression and the worsening of his physical complaints coincided with the final split—between tender and erotic feelings—in his marital relations some seven or eight years before. This account was accompanied with intense affect and much of its physiological concomitants.

It was also established that it was the patient's wish to practise birth control, and that once early in the marriage when there was a delay in his wife's menstrual period, he became enraged. He loathed having a child, especially a daughter. Several of his dreams centred around pregnancy and emphasized his very ambivalent feelings toward the pregnant mother. His concept about sex relations was filled with sadistic components, and his regression from the oedipal conflicts to the anal fixations was starkly prominent. The following dream may suffice to illustrate this point: 'It was a horrible accident. There was a mountain or a camel, and

there was a plane which dashed into it, more than once. It came back and dashed into it again and again. The back of the mountain was broken, and subsided. It was cut off from the waist. (Earlier in the hour the patient was complaining of a pain which he described as 'a sharp pain which cuts across the waist'.) I was standing with a man and his wife. I had a pleasant sexual feeling, and wished the man would disappear and let me enjoy the company of his wife.' Work on this dream led to his talk about his fascination with feminine necks and breasts, and also led him to disclose a lot of resentment against the analyst for having charged him, several weeks before, for an hour which he had missed.

Aspects of his identification with the father occurred more than once, especially in the new manner and language he started to use in acting-out. More light was thrown on his Don Juanism, and he admitted that he was faithful to his wife for only a short period after marriage, and was very disappointed to find himself unable to give up his shifting from one woman to another. Once while he was trying to find an explanation for this, he said he must have been looking for something missing in each one of them, and not finding it, he went on with his continuous search. Many dreams clearly showed much anxiety about passivity and the attempt to cover it with active homosexual leanings, which was mixed up with the earlier reactions to the loss of the mother and the attachment to the dangerous father, his terror of castration, and his repulsion from female genitalia.

Together with the abundant material dealt with and the intense tempo of his progress in the analysis, a remarkable symptomatic improvement was achieved and maintained. He began to eat whatever he fancied, after strict dieting for years; stopped completely the resort to medications; and broke the news of his analysis to his wife and to some of his friends. He was no longer constipated, reporting that for the first time as far as he could remember he passed a second stool in one day; and jokingly asked me for a percentage of the fee he paid me, as a reward for being a good patient. Most important was the revival of a more integrated, tender, and erotic attachment to his wife, and his yearning for a fuller love-life with her became more genuine and very acutely experienced.

But on his way during a vacation to join her at a summer resort, thrilled with the prospect of a much-delayed second honeymoon with her, he

lost his life in the crash of a big commercial airliner.

Some time afterwards, his wife came to me for analysis. She was still in mourning dress, but did not seem to be in too much grief; neither did she complain of depression. Only she mentioned some feelings of insecurity and anxiety, a mounting feeling of indecision, and a slight insomnia.

She was a very pretty-faced, fair-haired, finely sculptured woman in her late thirties. Her approach was a remarkable admixture of suppleness and ease of manner covering up a cleverly veiled strong will and tenacity of purpose. She was well educated, widely read, intelligent—probably very intelligent.

She was born and brought up in a very prim and puritan community. The mother was said to have been an able woman, who dominated the household not only by her ability, but also by her seemingly hysterical simulations of the martyred victim. She shared the father's business, and was the shrewd partner who built it up. A prominent figure in the household during the patient's childhood was a gay and flirtatious uncle, who used to make mysterious visits to the big city, where he painted the town red. A religious, conservative spirit, together with an ambitious financial struggle, permeated the household. Childhood years were free from any major stress, except the yearning for the parents, who ran the business, and particularly the mother, who gave the children little time.

The patient was the second among five siblings. She did well in school, got a university education, and followed some artistic pursuits in music and poetry. Around the age of 21 she met her future husband, married him against the mother's protests, and left her country with him for his homeland. She had had to seek psychotherapy twice before, once during her engagement and the other time a few years before she came to me.

During the first phase of her analysis, she confined herself mainly to a detailed narration of her early life, beautifully presented, carefully dissected, and artfully dramatized. She also developed an eye tic and a circular compulsive movement of the right hand over the face.

One of her screen-memories was of being in a children's hospital, waiting her turn to be lifted up to the examination table, and the mother's looking weird and secretive. The patient insisted that she was swabbed, and said: 'The worst

thing she did to me was sexual. It goes back to that table.' And she accused her mother for the loss of her virginity.

She mentioned, also, her attachment to that gay uncle, and how she used to sneak into his room to inspect the condoms he used, or out to observe and smell his underwear on the line, especially after he fell ill with intestinal cancer, and her mother's saying that it was the result of bad habits, which rotted his inside. Her infantile sexual play and phantasies were mainly with her sister, with whom she played the role of the father.

In spite of her technical knowledge and intellectual enlightenment, she used to think up to the time of her marriage that a woman could become pregnant through touch. She had bizarre ideas about pregnancy and childbirth, mostly of an anal nature, and not unconscious. She had a strong fear and intense disgust of menstruation, together with the notion that she might give birth to a child while bleeding. An intriguing fact, due partly at least to this belief, was that her menses completely stopped, once her husband ceased to have any sexual contacts with her.

For a long time her talk about her marital life was scarce and affectless. When she started to voice her complaints, she said that sex was given to her not as an expression of love, but as a form of play. She was called 'the little one', and was treated as if she were a toy. She was endeared in public, showered with kisses and held in arms, but harshly and sternly treated in private. Her day started with a rationed kiss, and at night it was again given to her as a reward for being good and doing well—exactly as the mother used to do with her. As also with the mother, she lived in constant fear of displeasing her husband, whom she adored.

As analysis progressed and the artistry of her defences began to give in, she started to act out, reasonably at first, but more and more wildly later. For a time she played with the idea of marriage again, but wavered between two handy prospects, the one a promising young man whom she could 'build up' and the other a very eminent but elderly statesman. She gave up the latter for the first, who was racially as far away from her as she could go. It was not even the various forms of her acting-out with this man, and later with others, but mainly the way in which she dressed up her accounts, that helped the analyst to understand what she was up to. For example, after getting over her prudism and starting to have intercourse, she told me one

day of a squabble with her young man, and in the course of her account she said, 'I slammed the door in his face, I would not let him in; it is just an act of revenge.' To which I acknowledged her admission, for the first time in fact, of her vaginismus which she had always denied, armed with the opinion of a gynaecologist to whom she had gone at her husband's request, and who reported that she had nothing anatomically wrong with her. She gloated at the reaction of her lover, who, though a man of the world, would pathetically explain that his failure to penetrate must be due to some anatomical difference between the races.

When her vaginismus was interpreted away, and sex relations were possible, she became very sadistic. Though the man had recently undergone surgery for hydroceles, she would excite him for repeated intercourse, and she would neither have an orgasm nor let go with him. She said that she was unable to because she wanted to prove that she was not frigid.

Having thus told me, also for the first time, of her frigidity, her sexual life began to unfold itself one leaf after another. She was soon to indulge in clitoric pleasures, and to tell me about this, together with her fear of the boys at school, a memory which led her to mention that her most vivid and frightful dream in adulthood was about being drowned in a water closet and being washed away in urine and faeces. Also, when talking about her masturbatory habits, she said that when her mother once caught her playing with a pencil, she hit her and turned her down on her face to inspect her. In answer to my query, the patient said that maybe she wanted to put the pencil behind. After a comment of mine on the possibility of her having been confused about the front and rear functions, she mentioned her husband's anal approach and said, 'The poor thing, that was his only way'. Later fellatio phantasies were talked of, to lead shortly afterwards to her practising simultaneous fellatio and cunnilingus, calling it new sex information, and equating it with the phantasy of being a boy sucking at the mother's breast and copulating with her at the same time.

More information was given about her attitude to childbirth. She said that whenever she suspected she was pregnant she cried and became very distressed. Also, she mentioned that about the time her husband rejected her physically, she became so constipated that she bled while defaecating, and had to be examined to exclude the presence of an intestinal cancer.

As analysis progressed, her acting-out was slowly controlled, only to be acted in the hours. She would feel cramps in her belly and wiggle on the couch as if she were writhing with the pains of childbirth. She also would compose limericks and recite poetry about fertility, and recalled Sarah's barrenness and the Bible's dictum that a woman has to have children to keep a man. But for her there was no easy solution. Her eye tic became very intense, and on leaving the hour she would flee away swiftly to the door while facing me, to avoid as completely as possible turning her back to me. Later in the analysis, when she was able to get over her fear of anal rape, the prim and proper lady would bid me good-bye at the end of the hour with a charming smile to the accompaniment of trombonelike noises which the analyst was too inhibited to interpret or even to draw her attention to.

With the slow decrease in her resistance, it was possible to work through the oral frustrations and anal desires and related reactions. From many angles the equation of the eye-mouth-anus-vagina was dealt with and was linked with the eye tic, the sucking mouth, the retentive anus, and the contracted vagina. There was also convincing evidence of the similarity of her attitude to the penis and to the breast, of her difficulty in tolerating frustration and her desire for continuous gratification, together with the rage against, and the fear for, the frustrating person. Once while voicing her resentments against her husband and his going around from one woman to the other, she linked it with her acting-out and said: 'I am now getting even. It might have been my frigidity, but I don't feel responsible for what he suffered.' But as she progressed further, she started to acknowledge how much she loved him, her grief became more acute, and mourning began.

The treatment of this case was successfully terminated; and over a number of years afterwards the improvement was sustained enough to withstand various adversities and to cope with the stress of readjustment to a different way of life.

Discussion

That is a bird's-eye view of the main features of the pathology of this couple, who nested together and were nailed into each other's life for about 20 years. Whatever label is used or theory adopted to explain their disease, there is enough evidence that the degradation of their

love-life went through the following sequence: At the start of their marriage they had a well-integrated relationship, but this lasted for only a short period. The husband's potency declined, taking the form of premature ejaculation, and the wife's partial frigidity set in. The husband began to bully her, and she meekly accepted the situation. Their sex relations regressed occasionally to masturbation or perverse practices. He resumed his Don Juanism, and they had no children, by mutual agreement. Their work and social life also underwent a change; but they still went on, until she belatedly knew of her congenital uterine defect, which seemed to have been the last straw which broke the remaining thread of their matrimonial harmony. He not only became completely impotent with her, in contrast to his pursuits with other women, but he even became unable to control his abhorrence when she came near him. In the meantime, she provided him with a plausible rationalization. She not only became completely frigid, but also her vaginismus made it an impossibility for him to penetrate, even on the very rare occasions when he was good enough to force himself to try. Nevertheless, the mutual adoration remained, with mounting degrees of guilt and hostility.

Such a pathological picture would naturally arouse a large number of questions. The following are only a few: Why did the marriage decline so soon after the good start? What made them cling to each other so long? Why did the wife seriously seek gynaecological advice at that particular time and not before, when it might have been possible to correct her defect? What determined their choice of each other? And just to stop raising questions, would they have fallen ill if they had not met?

In answer to these questions, the glimpses which were given before show that each partner fled into the marriage from unbearable homosexual attachments. But it is also intriguing to find that in their choice of their partners they fled into images that led them further back into their childhood attachments, she to a dark, despotic, frustrating object, a replica of her mother, and he to an apparently meek and helpless woman as his mother was said to have been. It is difficult to single out the reason for the decline in their marriage. It might have been the husband's inability to tolerate his anxiety connected with the possibility of her conception, a possibility which she played up whenever her menses were late, and used to cry under his own eyes and lament her youth and the beauty

of her body. As years went by and the compensation in work or society life was not enough to sustain their balance, came the decision to stop birth control. At this point his identification with the castrating and promiscuous father was not enough to keep him going. The patient developed physical symptoms, the fits of depression, and a total split between his tender and erotic feelings towards his wife, let alone his pregenital regressions with other women, thus reliving the traumata and the infantile reactions connected with his mother's pregnancy, the birth of his brother, and the mother's death, which he suffered at the peak of his anal stage. From then on, his identification with the lost mother and identifying his wife with her became the main factor in his life.

On the other hand, it was the wife's approach to the climacteric, assaulted by a possible psychophysical presentiment of the final verdict of her congenital defect, so far unknown or ignored, on top of her increasing inability to tolerate living in a community where there was a very high premium on motherhood, then the gynaecological verdict that it was too late to do anything about her infantile uterus, which brought her to the breaking point altogether. In her husband she re-encountered the father who gave her mother a pair of children at the peak of the patient's oedipal phase. She not only started to follow the mother's ways of life, but she slipped back further to experience the early conflicts about the mother's pregnancy and the birth of a previous sibling when the patient was in her second year. She also relived her infantile traumata in her vaginismus, her ambivalence, and her stubbornness, as if her husband had become to her the mother and was fully identified with her.

But, after all, what was the cause, and what was the effect? Was the cause a matter of constitution or of life experience; of instinct or of environmental imprints; of biology, sociology, or psychology? In reply to such a question the analysts may be able to get by with quoting Tolstoy when he said: 'When the apple is ripe and falls, why does it fall? Is it because it is drawn by gravity to the earth, because its stalk is withered, because it is dried by the sun, because the wind shakes it, or because the boy standing under the tree wants to eat it? Not one of those is the cause. All that simply makes up the conjunction of conditions under which every living organic elemental event takes place' (Tolstoy, 1865-8).

The analyst, however, may be pressed further to give a more definite answer and to tell us, at least after such an extensive investigation, what and who was the culprit and who was the victim. And here again the analyst may try to get by with quoting a seductively peace-making dialectician who once said: 'We say you are wrong; you say we are wrong. Solomon probably would decide to split the blame down the middle' (Mikoyan).

Yet on the slippery road of compromise the

analyst ought to step only with absolute caution. He need not renege his agreement with the other scientists on the plurality of causes. The accumulated evidence of psycho-analysis and the ethical implication of its very existence as a theory and a practice show that, beyond the multiplicity of all the levels of determinants, the human mind, with its own complexity and its increasing autonomy, is the major force that directs man's destiny.

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SOME CONSIDERATIONS FOR THE FURTHER DEVELOPMENT OF PSYCHO-ANALYSIS

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Psycho-analysis, like Caesar's Gaul, is divided into three parts: a method of therapy; a technique for investigation of psychological processes; and a theory of mental functioning, including health as well as illness. In terms of the last, it is a *general* theory of psychology. The second and third functions have, in some quarters, been displaced by the first, and this has had a detrimental effect on the broadest development of psycho-analysis as a discipline. A consequence of this increased emphasis on psycho-analysis as therapy has been a proportionate weighting of this aspect in the training programme. The special problems resulting from this latter development will also be considered in this paper.

What has produced the emphasis on the therapeutic aspects of psycho-analysis at the expense of its other functions? This derives from a number of factors: the greater general acceptance of psycho-analytic ideas with the resultant tendency towards dogmatism, social pressures for treatment, and the close union, in America, of psycho-analysis with psychiatry and medicine, with their natural emphasis on treatment. It is also related to current cultural emphasis on what is 'practical' or 'applied', as opposed to basic research. This is a theme which will be further elaborated.

It is not necessary to minimize the therapeutic aspects of psycho-analysis in order to maximize its broader aspects as a technique and a theory of mental functioning. It is in the clinical endeavours particularly that we establish the basic groundwork. However, one of the questions which must be raised is: What is the analyst's most useful attitude in approaching his work, from the point of view of the analysand and of psycho-analysis as a science? It is evident that we cannot rest on our clinical laurels, but must move beyond these in the direction of a more adequate general psychology. Each analyst must consider himself not only a clinician, but also a contributor to a greater body of

knowledge. If he limits himself to a purely therapeutic outlook, he loses much.

Emphasis on psycho-analysis as therapy alone (or as training) may induce a condition in the analyst which is a hindrance to his ultimate usefulness. A wider outlook need not make for indifference to the welfare of any individual patient. The basic question is what the breadth of orientation of the psycho-analyst should optimally be. In the long run (which is the crucial aspect) he will contribute more to the understanding of human behaviour by a broader perspective. In addition, greater clarification of basic premises and a firmer systematization of really extensive knowledge will lead him to greater clinical proficiency as well as increased ability to contribute to areas which are not directly related to clinical practice. There is much need for what we alone can provide.

Greenacre (1961), among others, in an article on the selection of candidates, defined the value of psycho-analysis, 'not so much as a technique of individual therapy but as an essential aid in the understanding and better handling of the wide variety of human problems'. She adds, 'it has always been recognized that the greatest contributions of psycho-analysis are indirect ones—the stimulation of new vistas in related fields of endeavour rather than simply the therapeutic gains to the limited number of people who can be analysed.' This has always been recognized, but it has also been quickly forgotten.

Long before this Freud (1887–1902) emphasized that psycho-analysis would make its greatest contributions as a method of research and as a general theory of psychology, not as a method of therapy, which he felt, for many reasons, would have a limited usefulness. It is hard to escape the conclusion that his general attitude toward analysis as therapy was, in the large, a pessimistic one, but the remainder of his statement still holds valid.

He wrote to Fliess in May 1895 (1887-1902, p. 119): 'My tyrant is psychology; it has always been my distant beckoning goal and now, since I have hit on the neuroses, it has come so much the nearer. I am plagued with two ambitions: to see how the theory of mental functioning takes shape if quantitative considerations, a sort of economics of nerve force, are introduced into it; and secondly, to extract from psychopathology what may be of benefit to normal psychology . . . A satisfactory general theory . . . is impossible if it cannot be brought into association with clear assumptions about normal mental processes.'

Later (p. 160) he said, 'I keep on coming back to psychology; it is a compulsion from which I cannot escape.' And (p. 162), 'When I was young, the only thing I longed for was philosophical knowledge and now that I am going over from medicine to psychology I am in the process of attaining it. I have become a therapist against my will.'

The conclusion is inescapable. The most significant values of psycho-analysis will be found in its providing a method for basic research, and in the contributions it can make toward a general theory of mental processes, and in its fertilization of allied fields. This, of course, is aside from the question of its value as treatment. The efficacy of psycho-analysis as therapy is a matter of much debate. There has unfortunately been little or no definitive research in this area. If psycho-analysis can be valued not primarily as a therapeutic instrument, but more in the general sense described above, much of this reluctance to discuss therapeutic results may disappear, insofar as it would reduce the burden placed on this aspect of the work.

Therapeutic efficacy cannot be the real measure of the value of psycho-analytic postulates. There are too many factors, not adequately controlled or measured, which affect this question. For instance, the effects of suggestion, both as regards the analysand and the analyst, the authoritative status of the analyst, spontaneous cures and transference cures and the influence of various life situations are but a few of the variables which potentially complicate our results and need evaluation.

Therapeutic psycho-analysis is part of an extensive constellation of affairs which are occurring simultaneously in the life of the analysand and the analyst, and all the factors which are operating contribute to the outcome. Psycho-analysis does not occur in a vacuum, but

is part of a life experience. The psycho-analytic experience cannot be looked upon as something separate and apart from everything else that is motivating or happening to the individual. All these factors need to be studied equally carefully. Waelder (1937) touched on many of these points.

Psycho-analysis is the most useful instrument yet devised for the microscopic study of human attitudes and behaviour. But it is only realistic to appreciate that the tool itself is in constant need of scrutiny, correction, and improvement (Hartmann, Kris and Loewenstein, 1953). In addition, it is necessary to define and accept the limits of any scientific discipline including psycho-analysis. Berlin (1958) said, in another context, but equally applicable here, 'the vagueness of concepts and the multiplicity of the criteria involved is an attribute of the subject matter involved, not of our imperfect methods or incapacity for precise thought.' We are dealing with most complex areas, and 'it is in principle, not merely in practice, impossible to reach clear-cut and certain answers. This may madden those who seek final solutions and single all-embracing systems. Human goals are many, not all of them commensurable, and in perpetual rivalry with one another.' The author added, 'principles are not less sacred because their duration cannot be controlled.'

To recognize these facts is not to take a defeatist position. The growing understanding of ego psychology can be of inestimable value in exploring the therapeutic situation itself. This is so not only in regard to the operations of the analysand but in understanding the role of the analyst also. Many factors influence the analysand, an equal number affect the analyst. The question of what goes on, in a total sense, in the patient and the analyst, and in the transactions between them, is an area that has by no means been totally clarified. But a few matters that merit consideration will be mentioned by way of illustration. Is the analyst motivated by therapeutic over-zealousness? Must every patient show improvement? Is he an apostle of a particular creed? Is he motivated by a desire to gain prestige or to win support for himself in the complicated power and prestige struggles that bedevil the analytic world? Is he contented to let his analysand find his own fortunes in life or must he place identification with himself and his goals as his first aim? Does he have particular moral and social goals which he needs to impose? Does he need to see himself as a special and indispensable person? Or is the analyst

able to take an objective view of himself as a person and an analyst and of his particular function—to analyse—and be willing to let the chips fall where they may? Does he have an objective and realistic view of analysis, with its virtues and limitations?

An honest appraisal will show that each of us is affected by certain personal attitudes that influence our work and our objectivity. The work of analysis, for the analyst as well as the analysand, is part of a life experience and cannot be divorced from other areas which are strongly invested. We cannot look at psycho-analysis in a vacuum. It is an intensely personal experience for both of the participants, and like everything else is affected by multiple determinants. These are conditions for the analytic situation, not contaminants as are the group mentioned above.

Psycho-analysis is an instrument which can make contributions not possible for other methods of investigation, and it is imperative that the method be objectified and rendered as free from error as is humanly possible. I do not visualize the analyst as a sterile, unfeeling precision instrument, but as a very human person though one who, in his humanism, is aware of the multiple motivations of both analysand and analyst.

Psycho-analysis is a unique methodology, but it must also constantly and deliberately be calibrated like any other tool. If the terms of an experiment or of an equation are not defined specifically the results can be meaningless, or even worse than meaningless, they can be slanted; that is, aimed at a particular goal. This may be the analysand's purpose, if not recognized in its total context by the analyst, or the analyst's goal, if he is not able to be aware, in himself, of his own biases.

Given that results *per se* are not primary criteria for psycho-analysis, it is essential to delineate what criteria are primary. The aim of our work should move towards developing logical and consistent concepts, which although derived from individual studies and experience, transcend them and lead towards a general theory of mental functioning. A word of caution is in order, 'that we cannot have everything is a necessary, not a contingent truth' (Berlin, 1958).

It must be made explicit that any theory or hypothesis is, so to speak, only for the moment. A useful formulation opens new areas, which in turn lead to new theory. We must not permit ourselves to be emotionally committed to final

answers or to give preference to one as against the other, except on experimental grounds.

A theory of mental functioning or behaviour must be looked at as a means to an end. Many of us, understandably, have a tendency to commit ourselves to an idea or a point of view and to resist new approaches or to feel that they are, by the fact of being different, unsound. Perhaps they are, but perhaps they also contain some germ of truth, some new viewpoint, which may contribute to the whole. But, regardless of this essential value, nothing is gained by rejecting any point of view in a cavalier manner. It must be weighed and its errors or truths dealt with by reasonable methods. If a new idea is invalid, this can be shown, or at least it should be shown that it is less useful as an avenue of approach than is our own. It is presumptuous even to postulate that there can be only one valid approach to so complex a matter as human psychic functioning. We do not have to sacrifice our own position in order to benefit from the insights of others. However, it is evident that 'To demand a unity of method and reject whatever the method cannot successfully manage . . . is . . . to allow oneself to remain at the mercy of primitive and uncriticized beliefs' (Berlin, 1958).

Since theoretical constructions must meet certain general conditions in our field as well as in others in order to be warranted, it is necessary to spell out these requirements, particularly as they may be applicable to psycho-analysis.

(1) Theory is most functional when it is most closely related to observation. Armchair speculation is valuable only when it can be checked against experience.

(2) A theory is measured by its degree of confirmation by others qualified to judge. This will inevitably involve study by many persons, with varying approaches and with varying backgrounds, but none can be disqualified simply because of these differences. In this area of theory formation and confirmation emotionally charged matters are apt to be touched upon, and it is necessary to be cognizant of this and to evaluate this factor with care.

(3) Theory is judged by its value in expanding and broadening its particular field and allied fields—by its heuristic value—its utility in furthering investigation and the returns which it offers.

(4) Theory is judged by its generality. It must be suitable for a wide range of application, otherwise it serves no useful function.

(5) No theory can be used to explain everything. Any hypothesis which is too broad and is not susceptible to disproof, to the extent that no conceivable observations could nullify it, is by its very nature, unscientific. It must inevitably suffer from the reductionist fallacy. There has been some tendency in psycho-analysis to develop this kind of theory, and when it is challenged to develop *ad hoc* explanations. Insofar as this is true, it makes for a narrowing of perspective and a non-inquiring spirit.

In the study of Freud's development we can observe many instances of a plastic yet constructive use of hypotheses. His first efforts, in the early papers, and particularly in the 'Project' (1887-1902), inevitably used physiological modes. Later he abandoned them because their heuristic value was minimal. For them was substituted a psychological model, because this conception opened wider vistas. Despite these developments Freud never totally abandoned the physiological concepts—he simply felt that they were as yet not adequately explored, and that in the end we might find our answers in chemistry and biology. In a broader sense, it did not matter whether one model was more correct than another—it was a matter of which viewpoint, at a particular point in time, was more useful.

In his thinking, his practising, and his teaching, it is critically important for the analyst to retain such an unprejudiced position. If he closes his mind or acts in ways which tend to do the same to his analysands and his students, he is doing a disservice to psycho-analysis as a science and as a therapy. Rather, let him encourage himself and his analysands to think independently and to explore the ways in which they themselves can widen and enlarge these very vital areas. Given a solid foundation in the best current knowledge, it is essential that the psycho-analyst and his analysand maintain awareness of its tentative nature and of the need to seek new answers based on the foundations already established.

Now, more than ever, we need to discover and encourage the growth of imaginative persons, well founded in classical knowledge, but not necessarily bound or limited by it; people whose professional or personal commitments are not such as to restrict them in their interests or their thinking. In the history of scientific and cultural development the most fertile growth occurs by the coming together and interacting of the creative person who proposes new ideas and the traditionalist who defends and conserves that

which has heretofore proved its usefulness. Along with this mutually catalytic experience must go the attitude that all scientific points of view must be looked upon as only partial approaches to the 'truth'. There are no absolute truths, and both of these points of view will be replaced in time by formulations which more nearly approach the whole 'truth'. Victory is in the striving. We will never reach the goal itself.

To put the matter somewhat differently, we must be strong adherents of principle, but not externally wedded to any given system of ideas. The marriage should not be easily dissolved—only for sufficient cause.

How can this attitude be approximated? How can a climate be created in which optimum progress can occur? It is widely believed that advancement and broadening are best stimulated by frank and open discussion of all issues—by open debate which seriously and conscientiously accepts all reasonable points of view and in which every individual engaged states the facts as they are known to him, offers the interpretations which to him best seem to fit these facts, and tries to make his underlying theoretical basis as explicit as possible.

In order to illustrate the potential impact of a developing area of scientific thought on psycho-analysis, some considerations of probability and causality will be presented. These topics were chosen, rather than others, since they have broad historical and prospective implications for psycho-analysis.

Psycho-analytic theory today, to a large extent, is still based on a deterministic point of view, although in other scientific areas this doctrine has been abandoned. It has been replaced in many areas by the theory of probability, yet we have not carefully considered the application of this relatively new point of view to our field. Hartmann (Hartmann, Kris and Loewenstein, 1953) seems to have been influenced by this development. His hypothesis of the 'average expectable environment' expresses a probabilistic rather than a deterministic point of view. In other words, development is a matter of chance, the factors being individual endowment plus or minus the environmental situation, but both are governed by probabilistic considerations.

A probabilistic approach would suggest that the given modalities in the form of ideas, attitudes, and behaviour would be based on information (in the psychic apparatus) as to the

relative success of this particular pattern as compared with a multitude of others. To a considerable extent any given modality may become automatic and rigid because most people will be exposed (or will allow themselves to be exposed) only to stereotyped stimuli—that is, familiar ones—either from within or without. Real growth and development can occur, however, only when we allow ourselves to become aware of and be exposed to the novel, the dissimilar, and the unexpected, whether internal or external.

It is an attractive proposition that new stimuli are those which, by their unexpectedness, arouse and encourage psychic activity and development in the form of creative activity or release from neuroses. The mind becomes aware of differences, and is stimulated to compare these with the usual, and is aroused to find new solutions. Some persons are unable to perceive anything that is new or different, or when they do so perceive will, by various mechanisms, succeed in again denying it. Maturation may, to a considerable extent, be determined by the capacity to accept and to be alert to differences, and to integrate them on the basis of previous experience.

Such a point of view indicates strongly the need for careful evaluation of the entire range of personality types if psycho-analysis is truly to become a general theory of psychology. Furthermore, it delineates for us the urgency of well-constructed studies of the exceptions; that is, why some persons are more open to the unexpected and why some people are more able to provide new solutions. It indicates a need for more thoroughgoing attempts to understand competence, success, and genius, and of the average member of the community, in addition to the neurotic and psychotic. Obviously a study of the failures and the inadequacies, the less than average, can be equally important and informative. But too much emphasis is placed on pathology and not enough on health and on what we might call the 'more than healthy'.

It is to engage in reductionism merely to hypothesize that psychic energy simply is released and somehow finds new and more constructive channels. Work is involved, not only in overcoming defences, but in arriving at new ways of functioning. This recommends the careful study of the available range of possibilities open to us. The analytic situation and particularly the role of identification should be rewarding areas for study.

The consideration of the theory of probability invites a re-examination of the concept of causality as commonly employed in psycho-analysis. A theory of causality must meet the following conditions. It must provide a reasonable explanation of the past, be consistent with present experience, and have the ability to predict, within reasonable bounds, the likelihood of future events. In addition, it must be consistent with and assist in predicting goal-directed behaviour, insofar as it relates to human psychology. In other words, the solution of the problem involves at least four factors in its equation: what has happened? what is happening? how will this effect what will happen? what is the purpose of what happens?

There are certain special problems intrinsic to and in some sense unique to considerations of causality insofar as it relates to this field. Any description or explanation must be put within specific boundaries of time and space, but must also include, as far as possible, biological, evolutionary, and social considerations. Even within the very short span of seventy-five years we have seen drastic changes in clinical and theoretical problems. It follows that there can be no absolute phenomena, but only those relative to the particular time-space factors. This concept may be confusing and frightening to some, but it is one of the new experiences previously mentioned without which there can be no healthy growth. Conceptualization and systematization may appear less rewarding if considered as no more than useful way stations, but this is more than offset by the release from a static world. It needs to be recognized that 'final truths' will never be reached. These considerations were foreshadowed in some of Freud's earliest ideas—that man is a biological creature and cannot be considered outside the general evolutionary process. In essence, no point in time and no concept of cause can have any permanent validity, but can be encompassed only on the basis of the evolutionary and therefore always-changing background.

In this light causality is always a multifaceted problem. One must consider the present characteristics of the individual, estimate his potentialities for adaptation and the diversities which have developed from these. One must place strong emphasis on genetic factors, both from the biological and psycho-analytic points of view, but it is essential to recognize the limitations of genetic theory as well as its strengths, and to allow sufficient room for

environmental factors. For instance, it seems likely that such things as memory, capacity for learning, and certain structural modifications are to a considerable extent not genetic in the strict sense. They exhibit a degree of flexibility, depending on and being influenced by life experience in its broadest meaning. These are evolutionary factors, yet they are, in an equally important sense, experiential factors.

Specific elements operate in a somewhat different sense; that is, the capabilities of the individual are strongly influenced by what experiences he has, what stimuli he is exposed to, or what deprivation occurs, essentially in relation to his stage of development at the particular time of occurrence.

Experience which covers broad masses of individuals is not specific for any particular line of development. The range of reactions in any individual is undoubtedly influenced by that individual's particular constitutional endowment and experience. His responses to an 'average expectable environment' will be a highly individual matter. Some of these variations either in the environment or the individual lead to disordered function, but it seems that many more lead to reasonable adjustments, or in some instances to exceptionally successful ones. As therapists we find ourselves more dedicated to the former, sometimes to the disadvantage of our patients and our science. This is one of the areas where the therapeutic emphasis on psychopathology has led us astray.

In general it may be said that capabilities fall into two broad categories. The first is what may be called the non-specific and general, relating in a broad sense to general capacities and potentialities; the second refers to the very specific qualities possessed by the individual and unique to him. Also in considering disabilities (and advantages) two broad categories must be dealt with: the non-specific cause common to individuals of the same socio-cultural group, and those causes unique to the particular individual.

There is a common tendency to think of causes in too specific a way—for instance, as a condition which is directly responsible for the occurrence of some event or without which it could not have occurred. A cause, or causes, are best thought of as being composed of a *group* of effectively associated factors without whose concurrence an event very likely would not happen.

Human motivations and attitudes are based

on physical-chemical processes, but this cannot be the total explanation. Affects and behaviour unquestionably involve other than the organic substructures. In speaking of an anatomical basis for behaviour, only partial answers are being offered. None of this really allows for the appropriate learning responses and the general tendency towards adaptation which allows growth and development in individual ways. These physiological qualities are common to all; they are 'purposive' and 'causal' but only in the most general sense.

As was mentioned earlier, it is generally assumed that a causal explanation must be judged to some extent by its ability to predict. Prediction (of the future) is a function of the extent to which we can describe, understand, and explain the past and present state of affairs. In view of the multiplicity of factors which effect human behaviour, it is not possible to attain the degree of certainty which exists in the physical sciences. This is not to say that we should not strive for explanations which would give us a high predictive value, but predictions, as well as causes, of highly complex human situations may be of a relatively low degree of accuracy. As persons interested in human behaviour, we should not be disciples of either a 'reductive' or 'seductive' hypothesis. The former would explain everything in a finalistic sense; the latter would hold that human behaviour is too complex and not governed by natural laws and that we should abandon our efforts to understand it at all. There is a middle ground which has been called 'scientific humanism' and encompasses both areas.

The middle ground is, as always, a difficult one, but from it certain perspectives can be developed. First, the adaptive abilities of humans vary tremendously, as do the stresses to which any individual is exposed. The word individual is the significant one. Perhaps, for individual, 'unique' should be substituted. Each person is unique, in the sense of endowment, interpersonal contacts, experiences, and the specific time at which they occur.

Humans are almost unlimited in their structural and dynamic development. Hartmann (Hartmann, Kris and Loewenstein, 1953) implied in the hypothesis of autonomy the possibility of the development and appearance of new modalities at higher levels of integration and in many instances quite independently of drive, conflict, and previous experience. This concept indicates also that when autonomous

qualities appear, even if they are the result of conflict or compromise, the new solutions are not necessarily dependent on the qualities of the component parts.

Conclusion

In conclusion, an attempt has been made to focus attention on two basic points. First, psycho-analysis has tended to stress therapeutic aspects as against its research potentialities and general psychological orientation; second, a clarification of certain areas is offered in the hope that benefits to our own science and allied fields may ensue.

It has been noted that psycho-analysis deals with indeterminate and multi-faceted problems. The suggestion has been made that the concept of probability offers advantages not inherent in the deterministic principle. Certain problems of causality have been considered and criteria have been outlined for these and for the value of scientific hypotheses, especially as they apply to the psycho-analytic field.

It is inherent in the theme of this paper that

psycho-analysis must not be limited either by a 'reductive' or 'seductive' hypothesis. It has been suggested that an approach best designated as 'scientific humanism' offers the broadest perspective for the work of psycho-analysis in all its aspects. This concept also embraces a sympathetic but keen scrutiny of all work in the area of psycho-analysis and in the many fields which are now impinging on it and to which analysis is contributing enrichment.

The essence of this paper might be expressed best in terms used earlier, 'in the history of scientific and cultural development the most fertile growth occurs by the coming together and interacting of the creative person who proposes new ideas and the traditionalist who defends and conserves that which has heretofore proved its usefulness.' Oppenheimer (1953) has said, 'When we find out something new . . . this does not supersede what we knew before; it transcends it, and the transcendence takes place because we are in a new domain of experience, often made accessible only by the full use of prior knowledge.'

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FAITH, TRUST AND GULLIBILITY¹

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Introduction: Importance, Definitions, Key Affects, Overview

The centrality of affects in personality theory is endorsed by many writers since Freud: Brierley (1951), Fenichel (1945), Rapaport (1942), etc. It has become apparent that some affects seem to have crucial positions in the psyche (e.g., greed, love, hate, envy, jealousy, bitterness, etc.) and thereby serve as nuclei for character sub-formations in what we term affect clusters. Descriptions of these affects appear in the literature. Some of these and other affects have positions of such importance that they collectively determine the overall basis for both degree and quality of perception of, and orientation to, the world. That is, the presence of one of these affects makes the experienced world a vastly different place for the individual from what it is without that affect, and this difference goes well beyond the specific affective experience.

The writers categorize 'trust' as one of such important affects. This paper will attempt to outline some of the ramifications of the presence or absence of this affect, the process of its development, and special problems related to trust. Alexander (1960) has already remarked that affects may be placed in developmental series, that one affect may be a prerequisite to the development of other affects, and likewise these later affects form the basis for development of still other affects. Alexander and Isaacs (1963) have discussed affective attitudes and their influence. These preconscious affective attitudes are thought of as forming in relation to affect clusters and in turn serving in the determination of deployment of cathexes.

In affective development certain key affects eventuate as an aspect of an epochal event. Six epochs of affective differentiation have been suggested elsewhere (Isaacs, K., 1956). These

may be described as: (1) the points of self-nonsel distinction; (2) the development of part-object relationships; (3) the shift from part-object to whole-object relationships; (4) the development of resolved whole-object relationships; (5) the shift from two-object to three-object relationships; and (6) development of complex multiple 'inter-reactions'. With each level of development, new affective experience becomes possible and the complexity of the perceived world increases.

The ego differentiation which occurs, does so in a step-wise series, and occurs at each of these phases in rather dramatic simultaneous advances in several aspects of the personality. At each epoch simultaneous affective, interpersonal, cognitive, conceptual, and other changes take place—in other words, broad lines of ego development are found. The ego capacities before and after such epochal events are vastly different. If the epochal event does not take place at the appropriate age, such shifts become increasingly difficult in proportion to the amount of delay. Thus it is exceedingly difficult to influence shifts many years after the appropriate age.

With the development of these stage-by-stage series of differentiations, the individual with these broad lines of ego development becomes capable of new distinctions. He can, at each stage, discern the psychological content appropriate for that specific stage, and can also comprehend the psychological content at whatever previous stages he has passed through. Some problems are involved in this for the immature person. Since at each stage psychological factors of that stage and of the previous stages are comprehensible to the individual, those differentiations still to be attained can be perceived only in terms of a grossness or a haziness, or else, more commonly, are blithely

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—adoption of clear roles, and definition of ego boundaries. There is also the appearance of new bases for tender feelings; that is, sympathy supplanting pity, tenderness supplanting scorn and contempt, cooperativeness supplanting 'law of the jungle', and time-binding supplanting biding of time. There is an increasing endurance of object relations, further superego development, and a new quality of introjects.

We consider the definition of ego boundaries to be a developmental task. When definition of ego boundaries is still partial and therefore not certain, much ego cathexis is allocated to defining and securing the boundaries to prevent encroachment. Persons who are thus engaged must necessarily be wary of others, if not actively distrusting. The perception of others interpersonally and in terms of object relations is distorted by concerns related to boundaries. Others are perceived as acting upon the self, or the self as acting upon others, not in terms of mutuality.

Trustworthiness is intimately related to trust. It connotes a serious commitment which stems from ego ideal, from quality of introjects, and from capacity to perceive the sensibilities of others. Trustworthiness is, in turn, perceptible to others as a characteristic distinctly different from the uncommitted, perfidious, and transient qualities in the relationships of untrustworthy persons.

Development of trustworthiness occurs with the formation of appropriately responsible attitudes toward obligations, considerateness for others, stability of involvement, etc. It is our impression that trust develops through both identification and validating experiences with trustworthy persons (Peck and Havighurst, 1960). It does so in a social matrix providing regularities and certainties of structure of interactions. The infant learns the reliability and repeatability of the care and consideration by the parent. He learns the consistency of parental behaviour. He learns the seriousness with which the parent regards his wants and needs. In such a relationship, over time, responsibility can develop, ego boundaries are defined, and concern about encroachment of ego boundaries therefore subsides. We do not take a stand on whether the development of trust secures the ego boundaries or whether the definition of ego boundaries allows trust to form. It seems probable that some precursor interaction occurs prior to the step-wise change. This is an important point which deserves research.

It is the forthrightness of parents in their dealings with the child which we think of as determining the fate of the child's developing sense of trust. The parents' serious involvement in the child as a worthy individual, and the moral qualities of the parents, are both adopted by the child through the process of identification, and thus trust, and especially trustworthiness, are related to superego formation. Schlesinger's paper (1961) has connotations for this process.

In a situation where a parent is not trustworthy, whether in large or small ways, a defect in the child's development of trustworthiness is likely to occur. Infantile faith, it seems to us, must be an almost universal phenomenon, developing as a consequence of early expectations of gratification, even where actual gratification is minimal. Faith develops, therefore, mainly from fantasy events. When a parent misuses the faith and the developing trust of a child, a disillusionment occurs which is a great blow to the psyche. If the child has a strong enough ego, he will integrate the fact as a determinant of limitations and restrictions on the trustworthiness of parents and others. If he has a somewhat weaker ego, the disappointment may connote a loss of the illusion of ideal parent and thereby mean a resulting bereavement, loneliness and depression. In such circumstances—anger over the loss of the illusion, and guilt over the anger—the distrust may be repressed, and leave the child unprepared to discriminate between trustworthy and untrustworthy persons. He has thereby become gullible, for he can only indiscriminately trust. Gullibility has to do with a persistent need to be deceived. The fact of being repeatedly deceived may serve additionally as a reassurance that the parents are actually no less trustworthy than anyone else.

There is what may be termed a gullibility or credulousness of innocence or ignorance, but most typically, gullibility is pathologically misplaced trust; the misplaced trust being the direct consequence of guilt. Guilt makes one deny knowledge which one really has. A notorious confidence-man, Yellow Kid Weill (Weill, 1948), is quoted as having said that all the victims mulcted were mulcted through their own cupidity. The victims denied their guilt, so that it operated unconsciously and made them victims, when their conscious wish was to victimize others.

Following definition of ego boundaries and development of trust, consideration for others and sympathy for others appear. The per-

ception of others through sympathy involves an identification with the other in a holistic sense. This, however, is not the same as the more differentiated empathic sensitivity. The latter point appears to be why trust can only be a necessary but not sufficient precondition to an analytic relationship. Integrative observation requires more than trust.

The differences between those persons who trust and those who do not trust is evident in their perceiving and experiencing of the realm of possibilities, for the realm of freedom is vastly enlarged for the assured (i.e. trusting and even faith-filled) persons in comparison with the unconfident, untrusting. A further difference exists between the perceived and subjective worlds of those who merely have faith and those who also trust. The factors which are weighed by each in decision-making are different. The unconfident, unassured person is always in danger, always threatened, lonely, fearful, and isolated. If one cannot judge who is and who is not trustworthy, he must choose among a few alternatives, for example, timid isolation, aggressive blustering attack to avoid surprise attack (thus retaliating in advance), or formation of transitory alliances which are uneasily maintained and which frequently and suddenly shift. He has to maintain a constant alertness because there are, for him, no cues as to from whom or when an attack will issue.

The trustful person has less anxiety about inner or outer dangers; this thereby facilitates new experiences. He lives in a world which includes friendly, cooperative persons. He anticipates acceptance by reliable and trustworthy persons. He experiences sympathy and compassion within himself and within others.

The non-trusting person has expectations of harm. He is always at least a little wary. The common affective experience is fright, for the world is perceived as a dangerous place. The gullible person perceives the world through unrealistic hopes for safety and comfort, for pleasure and gratification. The realistically trusting person is able to know when to be wary, but can discriminately relax in safety and confidence. In this sense, trusting and non-trusting persons are worlds apart.

The perdurant refractoriness of lack of trust is illustrated by a patient who had been seen twice a week for three years. She had not felt close to anyone since the beginning of the oedipal phase, and had no memory of fully trusting anyone since that early period. Needless to say,

she had no more trust for her therapist than for anyone else. Her distrust, which interfered with treatment in many ways, was discussed in therapy many times. In one such interchange she said, 'Why should I trust you?' The therapist replied, 'Why shouldn't you trust me?' To this the patient responded, 'I don't know you. If I trust you, and I am mistaken, I may be hurt by you.' The reply of the therapist was, 'You have seen me many times, but you are still afraid to trust me on the basis of those experiences?' The patient's reply was, 'That's not the point. Even though you have not harmed me in the past, how do I know that you won't in the future?' That question, by which the patient meant, 'How can I feel trust when I do not?' is not a question we can answer. But we can suggest the process by which trust can develop. Non-trusting persons have, in angry despair, been convinced (have reached conviction in which no open-mindedness remains), that no one is trustworthy. They will no longer apply the inductive method. They no longer doubt. They have reached a negative certainty. This certainty about there being no trustworthiness to be found anywhere in the world is denied, while consciously they think they are willing to give others the benefit of the doubt. But, certainty precludes further testing.

Trusting involves perception and judgement. It involves reality testing for the presence or absence of trustworthiness. If trustworthiness is found, there follows the intrapsychic act of trusting which involves the willingness and the ability to make a commitment to an object deemed trustworthy.

For the person who does not trust, the fact of experience of safety in a relationship, even when repeated hundreds of times, does not result in learning; the inference he makes is that he has been safe only because of his alertness. He does not infer that he is with a trustworthy person. There is a duplication of this in the international scene, and it is at this point that the dangers in international relations are awesome. Proponents of unilateral withdrawals as a means of teaching non-trusting cold-war opponents that we are trustworthy, do not realize this last fact. With an attitude of distrust, learning of safety does *not* occur. Conditioning experiments are not necessarily applicable to all human learning, nor does it seem likely that international conflicts can be solved in this way, for it is not a matter of simple conditioning where some learning occurs with every trial.

Gullibility is a dangerous risk internationally just as it is interpersonally.

The patient referred to had been loved and well treated until the age of four. At that time two events occurred, which proved traumatic. There was the birth of a sibling and rejection by a prudish father when she turned to him erotically for comfort. Nevertheless, the fact of her early trusting formed a bedrock to which the therapy could return. Although with exceeding slowness, the therapy progressed, and with recovered trust the patient was finally able to enter analysis.

In contrast, a patient who grew up from infancy in a situation which was fraught with uncertainties, inconsistent loving acceptance alternating with open rejection, could not trust. She was seen weekly for two years. She appeared for treatment as a lonely, suspicious young woman, with many hysterical symptoms, each of which appeared for varying lengths of time, disappeared, or were displaced by others. She had undergone many medical and surgical treatments which were costly, time-consuming, and ineffective. Bitterness about those and other experiences, as well as towards her parents, was intense.

She had experienced so little of relationships with trustworthy persons that she could not discern whom to trust and whom not to trust. She was therefore non-trusting. Her guilt over her rage at her untrustworthy parents forced her to deny her distrust. She was unconsciously determined to prove everyone untrustworthy. If they were, she would gullibly fall a victim to them. If they were trustworthy, she then had to prove delusionally that they, too, were untrustworthy. Because of this, she repeatedly put herself into positions which could not but end in disappointment, if not harm to herself.

She had never in her life developed what we consider a trusting relationship. Instead she had a blind faith, and a strong need to believe and rely on others. It is perhaps a tribute to the human race that she was not gulled constantly, for she was always ready to believe on first acquaintance, and always quickly disappointed. She rarely distrusted before and always distrusted after involvement. At base, she could not trust others, although she gave the appearance of trusting. That is to say, she was always suspicious and distrustful, but by denial of her distrust became gullible. The treatment was foredoomed to failure.

A third patient, a man of 21 when he started

treatment, was seen for one and a half years, then following a two-year interval was seen for one year, and following another two-year interval was seen for three years. At the beginning of the first course of treatment he appeared to be a young man heading for either 'skid row' as a drunkard, or to a penitentiary for his criminal activities. He had never held a job for longer than one day, drank liquor to the point of blackout, and had a history of various anti-social acts. He obviously did not trust, considered that everyone was out for himself, as he himself was, and could not perceive kindness or trustworthiness in others. He was bitter, resentful towards society and towards his parents for their inability to cope. His infancy, despite the economic impoverishment, was filled with acceptance from his mother. His father was a brute-like but not unkindly man who worked hard and regularly on a menial labouring job each day and drank himself to a stupor each night. The patient's capacity to have resentment about the differences between his life and the lives of some about whom he could read, plus his fears for his future as he saw his childhood companions become derelict alcoholics, inmates of penitentiaries, and some undergo capital punishment, created an urge in him to rise above his apparent prospects, and a motivation to seek help.

But, he could not trust. Even though many changes occurred, for years his psychotherapy was marked by a wariness and a limitation on his frankness. Although trust had been a subject for discussion several times, only seven and a half years after he had initially started treatment did the following interchange occur.
Therapist: 'You don't trust anyone, do you?'
Patient: 'No one' [pause] and here added something which he had never before stated to anyone. 'Except you [pause] a little.' He then appeared surprised and frightened about what he had imparted.

From this point he rapidly and dramatically changed in many aspects of his life. He adjusted to his work better, started planning to join a fraternal organization, controlled his wife-beating tendencies, expressed wishes to do kindly, helpful, and cooperative things for those around him, attempted to induce his wife to join a church for the sake of the more enduring relationships possible there, and abruptly stopped his lifelong petty thieving. He had simultaneously developed both trust and trustworthiness, as well as sympathy and compassion.

The fact of allowing himself to trust enabled him to perceive the world differently. He knew that the fraternal organization was comprised primarily of trustworthy persons and also knew that many of the persons whom he had known from the past were not trustworthy. The treatment continues under the beneficence of trust; and there seems to be some likelihood that he will continue to progress and develop. Regardless of future progress, he seems certainly secure in the role of a useful and constructive citizen.

The above illustrations may serve to indicate the function of trust in therapeutic activity. It is our impression that trust may rarely develop in the therapeutic situation, but forms an absolute prerequisite to integrative psycho-analytic activity. Thus, childhood trust forms a basis for treatment trust. In contrast, infantile faith forms a basis for magical, sometimes silent demands on the analyst.

When the patient distrusts (as with the typical paranoid patient), psycho-analysis, insofar as it requires a mutual participation with the patient freely imparting, cannot occur. When the distrust is in the nature of the less malignant but still pathological immature distrust, there are the restrictions of wariness and guarding which stand in the way of the analytic process.

One of the common forms of absence of trust in psycho-analysis is the transitory mistrust which occurs on the basis of projected abhorrence against the emerging unconscious material. So long as the feeling is *mistrust*, the analysis may remain on sound grounding. If the absence of trust takes the form of *distrust*, the analysis is likely to falter if not terminate. The mistrusting patient diminishes his credulity and thus his capacity to take seriously what the analyst says. The distrusting patient carefully fends off the analyst, and the analysis.

When a patient's affective attitude towards his analyst is faith-filled, there is a tendency to have complete belief in the analyst with an unquestioning expectation of (magical) results. The blind and unquestioning faith leads to a degree of credulousness which blocks perception. Such a person will undauntedly try or accept any comment, interpretation, or suggestion of the analyst. He will try strikingly different reformulations without question. Faith quells anxiety and forestalls close examination of a situation.

When the patient bases his expectation of analysis on a faith affect cluster, there is usually a blind and hidden grandiose expectation of

gratification. Such a patient believes that change will occur regardless of the kind or amount of his participation, and there is the expectation of magic or miraculous change brought about through an omnipotent analyst who is expected to perform miracles to enable the patient to be comfortable, content, happy, satisfied, gratified, relieved, and pleased, regardless of the circumstances in which he might find himself; and he expects that this will be achieved without his having to take any active part or having any responsibility for the process. The patient with faith is a poor prospect for psychotherapy, and a highly improbable risk for psycho-analysis.

In contrast, the trusting patient has the belief that the analyst understands something of people, of a treatment process and technique; and that if the patient participates in the process there is a reasonable likelihood of cure. The trust in the latter case has to do with a real person with real qualifications and real limitations, and there is an interpersonal object relation which is quite different from the fantasy component in the attitude of the faith-filled patient.

Religious Conversion Experience

We would like to make brief mention of trust and religious experience. The religious experience of the trusting differs from that of the faith-filled. For instance, the religious conversion experience may occur as either an upsurge of blind faith, or as a result of a surge of trust. If the basis of the conversion experience is partly that of the projected omnipotence, as occurs, we believe, in many revivalist meeting experiences, we expect that the endurance of the conversion is likely to be brief. If the basis of the conversion is actually that of development of trust through the process of identification and slower testing of doubts, then the tenure may be enduring. Thus, the quality of the conversion experiences are quite different; even though, superficially, they may appear much alike.

Trust and Whole Object versus Part Object

Trusting another person requires that the other person be seen as a whole object. Prior to whole object perception, trust cannot occur. That is to say, the notion of trusting another when the other does not exist as an identifiable and definable whole object is a contradiction, for one cannot trust knowingly a part of a person.

Paranoid suspiciousness is of special interest in relation to trust, because it is in the paranoid

states that some of the most marked pathology of trust is to be seen. The suspicious distrustfulness of the paranoid is notorious. Hate, spite, vengefulness, and jealousy are also paranoid affects and appear in the absence of realistic justification of these feelings.

We would like to make a distinction between the suspicious distrust of the paranoid and the 'normal' distrust that everyone feels from time to time. Time considerations prevent a full elaboration of this matter, which must therefore be left for another paper. We would, however, like to suggest that the paranoid's suspicion is related to his projecting outward certain feelings and impulses which his morality will not allow him to admit as being a part of himself. He thereby, to some extent, reduces or fractionates his self and, willy-nilly, others. In a sense, therefore, he has reverted to part-object relationships and the pre-trust stage; and in another sense he has shifted to a peculiar fractionation of object relations which is *unlike* infantile part-object relations.

Another aspect of paranoid development has to do with the fact that the superstructure of paranoia is erected upon a base which has its origin in that stage of psychosexual development which Freud (1911) called the 'pleasure-ego'. In this stage of development the older infant or small child looks upon any pain as originating from without. All the good, that is, the pleasant, it attributes to the self; and all the bad, that is, the painful, it attributes to the external world. Everything painful is thus seen as persecutory. The child who is loved, made secure, cherished, comforted, allowed nonetheless to be free, will be spared excessive pain, and so spared excessive persecutory feelings. However, the pregenitally traumatized child will enter the oedipal phase under a handicap of poorly resolved conflicts. These excessive conflicts will make it likely that

the child will not traverse the oedipal phase of psychosexual development successfully.

We do not regard the fact that everyone has some suspiciousness as due to the failure or even partial failure of the positive Oedipus to triumph. Those minimal paranoid traces we think of as due to the continuing effect of the universal experiences and reactions in that part of the preoedipal period called the stage of the pleasure-ego. Thus an ultimate theory of paranoia we think of as requiring distinctions among normal traces of suspiciousness, healthy and appropriate distrust, and paranoid suspiciousness.

Summary

The concept of trust is complex. We have had to use words such as faith, trust, and gullibility, although the precise meanings and differences among these words are often clouded by common usage. What is most important is the sets of relationships surrounding each of these concepts. The amount of receptivity to and cognizance of reality, the differentiated or undifferentiated response to reality, what goes into individual predictions, what for each individual constitutes verification, and how the individual relates his past experiences to his present and his future—these are ways in which the subjective worlds of individuals vary. Trust is one of the important determinants of the subjective world. Trust has roots in the earliest experiences of the child; has necessary preconditions for development; has an orderly developmental sequence. In any individual there may be appropriate development, limitation of development, maldevelopment, or defence against use of the capacity to trust, and pathologies in relation to trust. The functional uses of trust in psycho-analysis and psychotherapy are discussed. Trust and social structure is mentioned.

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ON BEING EMPTY OF ONESELF¹

By

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There is an English phrase 'He is full of himself' which means that the person in question is happy and proud, having accepted himself and his achievements. In other words he is identified with himself, either permanently or, at any rate, for the moment. The opposite phrase—'He is empty of himself'—does not exist in the English language, but related ones such as 'He doesn't look himself today' or 'I don't feel myself today' are quite often heard. They always mean that there is something wrong with the person, and the last conveys in addition that a feeling of uneasiness is present. It is not clear whether the ego or the self is wrong, but what is clear is that one feels the other to be dystonic.

This paper brings some clinical material to bear on a very complex area of psycho-analytical theory, the relation between the ego, the body, and the self. Here highly uncertain boundaries separate the various concepts proposed. To mention a few: Freud in 1923 introduced the concept of the 'body-ego'; later Federn (1926) speaks of 'ego experience' and 'ego feeling'; Schilder (1923) of the 'body schema' and later (1935) of the 'body image', which was later taken up by Scott (1948). Hartmann (1950, 1955) and others speak of the self and of self-representations, and the relationship between them and the ego. Since I do not intend to start my paper with a number of intricate definitions, I shall use only the concepts of self and the development of the self, and will not either clearly delineate or even touch upon the parallel and possibly even sometimes identical processes that lead to the acquisition of a properly functioning ego and superego.

In our clinical work we quite often see people—either moderately or severely ill—for whom the description 'he is empty of himself' might be helpful. The feeling of emptiness may be rather mild or very severe. To mention a few of their characteristic difficulties: these people do

not like to be left alone, and they find it difficult to do anything for themselves by themselves; in spite of this, they often dread human contact and resent being helped by others. They may appear merely inhibited; they are perhaps shy in company, easily embarrassed, awkward with their hands. In some cases they can hide and even overcome to some extent their inadequacy and feeling of emptiness, and can be active and successful, though never satisfied with their activity. Under favourable circumstances they are also able to keep up a more or less normal social life, where they can be very popular.

At the other end of the scale, these people have to withdraw completely from everyday life, but this withdrawal, instead of helping, aggravates their state and may lead to a sort of confusion. If hospitalized at this point, the patient's confusion may be halted or even diminished, because he is cared for without any obligation to those caring for him, i.e. the patient is not alone—but not actively with any one.

How can one understand the co-existence of these two apparently unrelated conditions: 'being empty of himself' and the need to have somebody there, although this does not make him feel better or more 'full of himself'? I wish to stress here that the presence of a real person may or may not improve the situation in mild cases. In severe cases, however, it never does.

I suggest that this disturbance in the relationship both to the self and to the environment originates in a fairly early phase of human development; perhaps in the area of the basic fault (Balint, 1958) or before or during the onset of the paranoid-schizoid position (Klein, 1946). Several authors have contributed to our understanding of this period, amongst them Ferenczi in the late twenties, Melanie Klein and Michael Balint in the early thirties, Winnicott, Anna Freud, Hoffer, and Greenacre in the late thirties and in the early forties, and more recently, Gitelson, Little, James, Khan, and Laing.

¹ Read at a meeting of the British Psycho-Analytical Society on 20 February, 1963.

What I can add to their ideas are some clinical observations on the possible psychogenesis of this feeling of emptiness. As will emerge in my discussion, this psychological condition is closely related both in its nature and in its chronology to the importance for the child of communication with his mother and her ability to provide for him a feeling of time for growth and development.

These observations might also contribute something to our knowledge of the special psychology of women. In my clinical experience the feeling of being empty or of 'being empty of herself' is more frequently found in women than in men, as already noted by Erikson in 1950. Further, this disturbance may be linked with another, which in my experience is also encountered more frequently by women than by men; namely that they are full of rubbish, which is valueless and lifeless, like sawdust in their Teddy Bears. Such women often say that they feel stuffed and uncomfortable, even after a small meal. From here various threads may lead to a theory of the symptomatology of anorexia.

Much help in understanding this condition can be found in the Kleinian literature, in their dynamic approach to the inability to take in and keep alive good objects inside the self, and in their ideas on the early onset of envy. These ideas, though valuable, seem insufficient, since the patient described in this paper was troubled more by the lack of self than of objects good or bad inside herself. True, she could not take in good objects. This could be connected with her oral attacks on her objects and later on her envy of them. In my opinion, however, the envy seemed only to arise after feelings of being empty of herself had been overcome (i.e. after the patient had acquired a feeling of self) and appeared to be connected with a more advanced stage in development than the one which I shall be describing.

The question arises here: have these patients ever felt that they were 'full of themselves', that they were really living in their bodies and were the same people, whom other people would recognize if they saw them from day to day; that is, did something occur to them in their development that created the feeling that their essence had been taken away from them, although they had once had it?

My paper is based mainly on certain aspects of the developing transference of a patient, whom I shall call Sarah, who was 24 when she was referred to me for analysis. I shall attempt

to show the ways in which I understood these aspects of the transference, and how I used them for therapeutic purposes. This selection cannot, of course, be taken to mean that other aspects of the transference were absent, or were not observed or used; only that I needed these in particular for my reconstructions and theoretical conclusions. I am stating this in order to avoid giving the impression that this analysis was one-sided, or that it consisted mainly in the aspects which I shall be describing.

Sarah's parents were well-to-do professional people from abroad. Her father was described both by my patient and her mother, whom I saw when she came to England during the analysis, as a man with a violent temper who was never able to control himself. He was disappointed when his third child, my patient, was born a daughter, although his two elder children were sons. The mother seemed a depressed woman with precarious self-esteem, who relied on her children to take her side in her stormy marriage.

Sarah was breast-fed and, according to her mother, there was always a plentiful supply of milk, and Sarah was a perfect baby. Very early she started to play with her brothers, who were only a few years older than herself, climbing trees and competing successfully with them in every way. She did well at school and at games, was good at horse riding. Her mother showed me a photograph of Sarah aged 17, so that I could see what a beautiful and glamorous girl she had been until the breakdown, which occurred soon after she arrived in London and which brought her to analysis. Sarah's mother could not understand how her daughter could have changed so much, and stated emphatically there had been no trouble at all until perhaps a year before the breakdown. The breakdown was put down to the fact that at that time Sarah's father had been particularly violent, and this might have worried his daughter. Sarah's mother's pride was deeply hurt by her daughter's illness. She was sure that if Sarah was spoken to sensibly she would be quite all right again in a few weeks' time.

During analysis, it became clear that Sarah had in fact always been in difficulties. She described how at a very early age she lay awake terrified in bed, frightened to call out, listening with panic to her heart-beats in case they stopped. From transference reconstruction it also appeared that from still earlier times she would lie rigidly in anticipation of some object descending upon her from above, and crashing on to her head.

This object was sometimes described as a rolling-pin, sometimes a rock, and sometimes a cloud. I also have good evidence for believing, although I was very doubtful whether this was fantasy or a reality for much of the analysis, that when she was about six or seven years old, the younger of Sarah's two brothers had intercourse with her, and continued to do so until she was about twelve. Her mother's failure to recognize the trouble her daughter was in at that time, as well as at an earlier age, was worse for my patient than the experiences themselves. Sarah saw herself at best as scorned, but usually as not recognized, not seen. In fact, as I will show later, one of the main themes in her treatment was the difficulty one person must experience in recognizing another (see also Laing, 1960). She could never understand how I should know who she was when I went to the waiting room to fetch her for her session.

Sarah came to England when she was 24 years old, in order to undertake some post-graduate training, but almost at once she became confused and acutely anxious and had to abandon her training. She managed to move to the house of some elderly relatives near London, and got herself referred to a psychiatrist. Once she broke down she was unwilling to work or to do anything except bring herself to analysis each day. She wore the same clothes all the time, winter and summer, and for most of the analysis did not take off a thick cardigan. She managed, however, to appear normal enough to travel on the train and underground. The relations with whom she lived tolerated her queer behaviour, with some support from me and from the doctor who referred her for analysis.

After the first few months of treatment and during the first phase, which lasted for about one and a half years, Sarah covered herself up with a rug and turned away from me. There were long strained silences and sometimes some violent outbursts of feeling, but usually a rather flat atmosphere was maintained; feeling was mainly shown when Sarah had to cover the distance from the door to the couch, which she did with some difficulty. During this first phase, Sarah experimented with my ability to tolerate her confusion and withdrawal. Her transference reaction was to expect that anything that happened between us, either her associations or my interpretations, would have no meaning. She said, as some other patients do, that she was sure that I must repeat the same interpretations automatically at the same time in the analysis

of every patient, and that perhaps I kept records of different sessions and played them over again in turn to each patient. But, instead of being contemptuous and angry as some patients are about this, she accepted as inevitable the fact that our relationship was meaningless. This material was interspersed with fairly coherent normal oedipal material, which demonstrated very strong penis envy, and also with accounts of many homosexual and heterosexual exploits. Her associations, though, were for the most part about, for instance, the wild animals which encroached on the city where she used to live, and how children were often swept into gutters and never seen again, and how frequently snakes were found and killed in the city. There was always a danger that termites might burrow under the foundations of houses and trees, and cause them to collapse. She was frightened of undermining me and of being undermined by me. I was seen as a whole separate person or animal, and she expected me to see her in the same way. She frequently said she would kill herself. At this stage she never looked at me, except for brief moments, but she constantly tried to find out if I would know when she was really frightened and when she only pretended to be so and, on the other hand, whether I would force her back to work and, in so doing, into her mother's world, which she experienced as a complete void. She dreaded the void more than anything else; much more than her own nightmare world. She was constantly strained and had difficulty in living—moving about—getting up—going to bed—everything caused strain and anxiety.

During this first phase of analysis Sarah's mother came to England and tried to remove her daughter from treatment and turn her back into the normal girl she really was. I had hoped she would look after her daughter for a time, but this was clearly out of the question. Sarah, though, was determined to stay in analysis and managed to take matters in hand. She passively resisted all attempts to make her go to parties and buy new clothes, but agreed to be seen by a very undynamically orientated psychiatrist. She was clever with the consultant, appeared to outwit him and led him to tell her mother that he could not take her daughter away from analysis for six months at least and that she should not be forced to work for that period. Soon after her mother left England Sarah's only intimate friend committed suicide. Sarah gave up attempting to look after herself, became

confused, terrified, and withdrawn, and I had to refer her to a mental hospital. She stayed there for three months and I was able to visit her occasionally. On entering hospital she was described as 'depressed, inert with marked volitional disturbances. No evidence of psychotic experiences.' Her personality was said to be schizoid, mildly obsessional, suppressed aggression, intelligence superior.

Shortly before this period of hospitalization, after about one and a half years of analysis, the second phase of treatment started, when one day Sarah noticed a piece of paper and a pencil on a table near my chair. She asked if she could take them and, when I agreed, she put the paper on a table near the couch where I kept an ash tray for her, and she began to draw. Her drawing was made up of little lines and dots and, although disconnected, gradually they filled up the whole sheet of paper. She then took another sheet and did the same thing again. This activity was not undertaken easily—as if giving pleasure or satisfaction, but with intensity and great effort.

After this, she spent part of each session drawing in this way. I interpreted this activity as an attempt to communicate with me and show me herself and her sensations and how scrappy and bitty they were, because she could find no words to describe them. It was not important if I did not then or later understand and interpret her drawings; but I had always to recognize them as communications, respect them and respond to them. On some days when I was perhaps less responsive, she would notice this and would withdraw but say nothing. I did not notice this for some time, but later she told me about it and said that it was all right because she now knew that I would probably be more alive the next day, even if I seemed rather remote on that day. The rest of each session was spent in normal analysis; Sarah started to recollect her dreams and to associate to them.

I kept her drawings in a portfolio in my room. Later, when she brought me paintings, I also kept her paintings, and it gradually became understood between us that she was giving me bits of herself, of her body, and that I was collecting them and keeping them in one place in my room. As time went on, the paintings, which of course she did at home, became more integrated, but not until towards the end of the analysis, in the third phase, did they represent whole objects; in this, the second phase, they were often quite clearly distinguishable part

objects, breasts, penises, ovaries and other parts of the body. Sarah had studied biology and used some of her knowledge, but nothing was ever complete, and nothing ever joined up with anything else until the final phase.

It was only during the third and the fourth phases of analysis (i.e. from the fourth year to the sixth) that Sarah was able to *speak* about her body. Before that she spoke of events and activities in her head, but these events belonged to the nightmare world in which, for instance, wolves constantly and ceaselessly chased round inside her head, or in which her head consisted of hundreds and hundreds of little bits like mosaic, each with a most elaborate picture on it.

This period, the third phase of work, was characterized by violent changes of mood, which were repeated session after session. Many of the sessions seemed to fall into three periods; the first a violent one, during which Sarah hit the couch or the cushions, clenched her fists, flung cushions on the floor, tore up her drawings and crouched away from me sobbing. After about ten minutes—when I had interpreted this behaviour—the second period of the session started, and Sarah almost seemed to collapse on to the couch. She then started to suck her fingers or some part of her hands, or she left her mouth open making sucking movements. She became quiet and then only after a time she started to speak, and the third phase of the session started. Her associations were of this character: she said she wished that she were a bat so that she could come into my room and sit on the ceiling, or that she could be a monkey jumping from branch to branch. She described how at the beginning of analysis she used to sit up on the ceiling, or on a cupboard in the corner. I had not realized, she said, that on the couch was only a shell with an eye in it. Or she would talk about beautiful streams, which were clear and good on top but poisonous lower down. She expressed vehement fear of death, of killing, and in particular of being poisoned. In this period, as in the previous one, she repeatedly threatened to kill herself. More meaningful work could then be done on her fear of her oral impulses and on the danger of projecting them into me and into her environment. At one point during these associations Sarah often turned round so that she could see me. She began to speak about her need for me always to be the same and about her astonishment that I could recognize her day after day.

When she left we agreed that she would write to me from time to time, which she did. To begin with she lived at home and was unable to settle in a job. In a letter written about a year after the termination of her analysis, she reported a dream which was an obvious continuation of the 'dog dream' and which I was therefore able to interpret in terms of her fear of loss of self and body contents.

In answer, she wrote that my interpretation was right. She had now reached the decision to move to another town and live with a woman friend; the following week she started a job, using her University qualification for the first time, which she has kept ever since (about one and a half years). Two months later I received from her mother, who had visited her, a letter in which she said: 'Her first few months here imposed a strain on her, but I was delighted at the self-control she was able to command.' And another passage added: 'To me she seems perfectly relaxed and is entering more and more into everyday affairs of life. I do feel now that the long years have not been in vain.'

I have also had letters from the friend with whom Sarah lives—a University Professor—in which she expresses appreciation for the work of analysis. She has asked me whether analysis always achieves such good results.

To sum up the course of the analysis:

Phase I. Lasting about one and a half years. A feeling of being empty of herself. The world is a void. Horror at having to do anything in it. No genital symbolism. Perpetual fear of the emergence of a catastrophe, or of creating a catastrophe. Much mental activity, which acted as an outlet for her destructive wishes.

Phase II. Lasting about one and a half years. Drawings, first of dots and dashes, recognized as communications about body movements and sensations, gradually developing into part objects and genital symbols. No attempt was made to understand the drawings in any other way. Analyst was allowed to keep her drawings. A false relationship was avoided as far as possible. The patient was able to store some of her feelings in the external world.

Phase III. Lasting nearly two years. Violent mood swings. Parallel with this, sucking movements predominated. She began to have feelings in her body and with them genital symbolism emerged, to describe the loss of feeling. As she filled up, the world filled up.

Phase IV. Lasting nearly one year. Paranoid persecutory anxieties became prominent; genital

symbolism and body feelings continued, though not without anxiety. Some adjustment to reality.

A follow-up lasting more than two years. Adjustment to reality developing. Professional and social life developing.

Let us now reconstruct Sarah's development on the basis of the material obtained in her analysis, supplemented by the data obtained from her mother. I shall, of course, have to draw on somewhat more material than I was able to report in the paper.

(i) Although there was plenty of milk and she was a good feeder, and on the surface developed satisfactorily, there was apparently a vitally important area where there was no reliable understanding between mother and daughter.

(ii) Although the mother tried her best, she responded more to her own preconceived ideas as to what a baby ought to feel than to what her baby actually felt. Possibly Sarah's innate ability to bear frustration and to adapt herself was limited. Possibly this experience formed the basis of the ever-recurring theme in Sarah's analysis—of not being recognized. Probably Sarah's mother could not bear unhappiness or violence or fear in her child, did not respond to it, and tried to manipulate her so that everything wrong was either put right at once or denied.

(iii) What was missing, therefore, was the acceptance that there might be bad things, or even good ones, which must be recognized; that it is not sufficient merely to put things right; moreover, that the child was neither identical with her mother, nor with what the mother wanted her to be. It was on this basis that the painful situation developed, where neither would identify with the other. The mother coped with this painful situation by denial, and the daughter by becoming 'empty of herself', which probably also served as a method of dealing with her anger.

(iv) Although I have not presented the clinical material in support, I would like to add a further aetiological factor; the mother's inability or unwillingness to provide unhurried time for the development and integration of the feeling of self.

I now wish to attempt to express these reconstructions in the terms proposed in this paper. Sarah's mother was impervious to any communication which was different from the picture she had of her daughter and, in consequence, Sarah could not understand her mother's

communications and felt that her mother never saw her as she was; neither found an echo in the other; and consequently only a spurious interaction between the growing child and the environment could develop. The mother and child could not, in Winnicott's phrase, 'live an experience together' (Winnicott, 1945). I envisage this experience as the child finding an echo of himself coming from his mother; or as the mother accepting her child's as yet unorganized feelings and emotions and enabling the child, by her reactions to them, to organize them into a self.

I propose to call this process a 'feed-back', which starts in the child, acts as a stimulus on the mother, who must accept it and recognize that something has happened. Her recognition results in a kind of integration, and this is then reflected, fed back to the child, in much the same way as on the biological stage the baby's sucking acts as a stimulus for milk production. This feed-back process presupposes an interaction between two active partners which, I think, differentiates it from projection and introjection in which one of them is only a passive object.

When one of them is only a passive object. Sarah's mother's unwillingness or inability to understand her daughter was evident even at the time when she came to see me in London. I was unable to make a workable contact with her myself, and it was clear that she was unwilling to try to understand anything about her daughter, or even to consider anything worth while listening to, that did not link up with her own ideas. She was in another world, incapable of enlarging her own experiences or taking in anything that was unfamiliar. I realize that it is impossible to draw a conclusion from this alone and to state categorically that this proved that Sarah's mother had been impervious to communications from her infant. My impression, however, was that for her mothering was an enveloping manipulating activity, where the infant herself had no potential, but was a kind of empty object in which she could or even must put herself, so as to gain satisfaction and reassurance; she could not see her child as an independent person in her own right. No doubt this can also be seen in her unhappy relationship with her husband and her inability to make a relationship with him.

We can now see why having somebody around her was not necessarily helpful to Sarah and why in fact, in many cases, it even aggravated her illness, although she could not bear to be entirely alone because if she were alone

there was no confirmation at all of her continuing existence. What was needed was a human being who realized that she was in another world and did not force her back into his world. I would like to add that the relatives with whom Sarah lived played this part to perfection. They recognized her singularity, but did not try to force her to live in their world, nor was their world quite 'conventional'. Neither of them forced her world on the other.

I wish to illustrate these ideas further by some brief clinical material from Sarah's analysis. For instance, the way I responded to her drawings allowed her to feel that I accepted her and did not try to force my standards of goodness and interpretability on to her and her pictorial expressions. In this way my reaction was acceptable to her and was even sometimes perhaps a proper feed-back.

My last illustration is a general observation about children. It is interesting to note how important it is for healthy children to be able to show a hurt part of their body to parents. When they hurt themselves, even if it is only in a very minor way, they usually run to their mother to show her what has happened, and she must accept it. They can then run off and play again. A proper feed-back is when the mother receives the hurt, recognizes it, does not make too much fuss over it, but just accepts its reality. It seems as if it was in this situation that Sarah's mother failed her.

By the way, lack of proper feed-back may also lead through a deficiency or superfluity of adequate stimulation to ego distortions. Parts of the ego may over-develop in trying to cope with the situation, while other parts may under-develop or become retarded. I cannot develop this theme here, which is, of course, only one of the causes of ego distortion, which have recently received much attention in the analytic literature (Gitelson, 1958; James, 1960; Khan, 1962).

To return to my main train of thought. Because of the lack of proper feed-back, the child, as well as the environment, got poorer; this ultimately resulted in the void outside and the emptiness inside; life only being lived in a fantastic and nightmare world dominated by id impulses, but out of touch with body sensations and feelings; or, to quote Ferenczi (1933) translated somewhat freely: in a world of 'thinking without feeling and feeling without thinking'. The infant tried to communicate, but got no response; nothing came back, everything

faded away; nothing was fed back, or what came back was not an echo or a response to what the infant felt or was trying to communicate. This lifeless relationship with the environment continued until a breakdown occurred, when Sarah was 17.

What was left in my patient was only aggression out of despair. One could interpret the meaning of the wolves chasing round inside her head as representing the patient chasing her mother, or the mother chasing her child. This activity, however, only expressed endless futile anger and despair. After a time, with no real feed-back, the object that was chased, or the object that was needed, became unimportant; no particular object was worth chasing or worth being angry with.

In addition, since time was not punctuated by periods of good and bad feed-back, the patient gave up hope that time would do anything for her, that there would be time to do anything in, or that time would bring about a change or growth.

For Sarah, the nucleus of herself was not based on feelings arising out of body-self-sensations, reinforced and enriched by responses from her mother to them, so her early introjections were felt to be alien, threatening to swamp herself. Healthy projective and introjective processes were stunted. The infant remained isolated from reality. In this connexion see also Erikson (1950) and Searles (1961). Hoffer (1951) also points out that in a child's development many situations of stress amounting to a loss of the feeling of self may arise. The patient cited by Anna Freud in 1954—an adolescent girl who had been a victim of the Nazi régime and who was smuggled out of a Polish ghetto as an infant—'told her analyst that she could not be analysed unless her analyst spent the whole day with her as she was a different person in different places'. Miss Freud says: 'She asked the therapist to offer herself in the flesh as the image of a steady ever-present object, suitable for internalization, so that the patient's personality could be regrouped and unified around this image. Then, and then only, the girl felt, would there be a stable and truly individual centre to her personality...'. She demonstrates the predicament of a girl who as an infant did not have the opportunity to develop a coherent self because of the lack of one single person with whom she could relate.

Since the early work of Freud, the paramount importance of a good mother-child relationship

has been stressed. The difficulty, however, is sometimes to define or specify exactly what 'good' really is. In this paper I have stressed that aspect of a good relationship where the mother is stimulated by her baby so that her reactions will be felt by her child as an echo or a proper feed-back.

Summary

A. Reconstruction of Pre-analytic Developments

(1) Sarah's mother did not notice, or ignored, or could not respond to, her daughter. She could therefore not provide the proper feed-back or echo which was needed. This faulty relationship continued during Sarah's childhood and throughout her whole life.

(2) Because of this lack of feed-back Sarah felt that she was unrecognized, that she was empty of herself, that she had to live in a void.

(3) If she was empty of herself, no one could recognize her; she was ignored, alone, and relatively safe.

(4) To have something, Sarah created a nightmare world which she felt was located in her head. This also served as an outlet for her aggressive impulses.

(5) In order to try to satisfy her parents, Sarah did well until she was about 17, although constantly suffering from strain and feelings of impending catastrophe, which went unnoticed.

(6) Finally the feeling of unreality became unbearable, and when she arrived in London (where she knew analysis was available) she broke down.

B. Developments During Analysis

(1) During analysis she became aware of her feelings of being empty of herself, expressed often as seeing herself outside her body. She felt that on the couch she was a shell with an eye in it. Inside she was full of dead people and objects.

(2) She then began to experiment with putting bits of herself into me (and my room) and getting my response to them. She gave me drawings, representing sensations, movements, and parts of her body which were collected in my room, as were her associations, she felt, inside me as I demonstrated when I remembered them.

(3) Sarah began to have body feelings—i.e. felt herself to be inside her body—and parallel with that the external void began to fill up.

(4) This led to fear of losing herself again and to a phase of paranoid anxiety.

C. Theoretical Conclusions

(1) It is well known that the ego and the self develop in certain respects spontaneously or autonomously by what is called maturation. In other respects, however, their development depends on a proper interaction between the growing individual and its environment.

(2) In this paper I have tried to describe one mechanism of the interaction which I have called an echo or feed-back. The infant, by his behaviour, stimulates the environment, and foremost his mother, to various reactions. Echo and feed-back can be described as what the mother contributes to the stimulus and reactions out of her self.

(3) The infant then gets to know what he is like in terms of someone else's—the mother's—experience; the mother lending her ego to integrate and reflect back the child's communications. The infant therefore gets to know himself, and his mother at the same time, by how she reacts to him. If the mother's reactions do not make sense to the child because, for instance, she is too preoccupied with her own ideas or feelings, then it is not a proper feed-back. On the other hand, good mothering, or proper

feed-back, is what makes sense to the child.

(4) There is no possibility of the development of a healthy self when there is no proper feed-back at acceptable intervals. My idea is that these need not be at fixed moments or periods. A few may be enough—and each can be valuable and start a development. (Possibly even a rejection or a reproof may be experienced as a feed-back if it makes sense to the child.)

(5) These ideas lead to interesting problems regarding technique, such as the difference between interpretations and feed-back, and the different treatment necessary for withdrawal or secondary narcissism.

To end my paper, I would like to say that in general, if the interaction between the growing individual and the environment leads to severe disappointment, two reactions can be observed:

(a) The increase of aggressiveness and hatred in the individual.

(b) Deficiency symptoms in his development. Sarah's analysis enabled me to isolate (more or less completely) this deficiency reaction, and led me to the theoretical conclusions which I have just summarized.

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THE SECOND ANALYSIS¹

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A current popular ditty states that love is better 'the second time around'. What is love, and how much better, the lyricist does not explain. He need only renew the hope that one can love again and again. The patient coming to the second analyst has the same hope, clouded by some disillusionment with the first affair. The analyst shares this hope, but like a widower's new wife, knows he too will be compared with the illusory past, and more likely than not, will also be found more wanting than wanton.

Indeed, a second analysis, like a second marriage, inevitably recapitulates the first, at least in the early manoeuvres. Here the analyst, unlike the new wife, must hastily familiarize himself with the gambits of the earlier analytic relationship before this second marriage drifts towards an equally unhappy dissolution. Multiple analysis, like multiple marriage or promiscuity, follows the same pattern: idealization and hunger, gratification, then depreciation, then contempt and fear, and finally flight to another similar sequence.

There is a curious disinclination on the part of analysts to relate their experience with patients who leave their colleagues, at least until they are old enough to realize that divorce is sometimes preferable to an unsatisfactory and stagnant marriage, and to know that many of their own patients have availed themselves of a more fresh and renewed opportunity in another therapeutic experience.

Analysts pose as non-judgemental of the trials and errors of their patients. They are disinclined towards such leniency either for themselves or their colleagues. Like a second wife, they hope for success and acceptance, but, unlike the wife, if they too are abandoned, they cannot protest that the philanderer was never fit for any marriage.

The patient seeking a second analysis presents a variety of diagnostic and technical problems,

concerning which the psycho-analytic literature offers no specific guidance. No model technique for a second analysis has been suggested. The second analyst needs to evaluate the residual neurotic conflict, the quality and depth of the previous analytic experience, residual transference hangovers, the added complication of intellectualized 'insights' which provide new opportunities for defence, and the economic and emotional cost entailed in further therapeutic effort.

Some of these patients, despite long analysis, present themselves as if 'nothing happened'. Their memory seems vague, almost amnesic for this prolonged and costly experience. Isolated happenings or phrases may be remembered, or general impressions may be offered, but the entire experience of the first analysis may have an elusive, discomforting, dreamlike quality. Others come directly from a confused transference involvement, anxious, still enamoured, or still violently antagonistic to the first analyst. In others there is an underlying pathological process which has progressed despite prolonged psycho-analysis. Frequently the patient seeking a second analysis presents only residual or current problems for which short-term 'clarification' is sufficient.

Separate from such immediate clinical problems presented by the patient, many questions arise concerning the validity of basic assumptions on the nature of the psycho-analytic experience, and the appropriateness of technical modifications which on a hindsight basis might have resulted in a more effective first psycho-analytic experience. Are there technical problems or characterological findings typical of most patients who seek a second analysis? Does the first experience alter the course of the second? Does it facilitate the second analytic experience, or act as a hindrance? How meaningful was the first analysis as a subjective intrapsychic experience, as therapeutically helpful, as helpful in effecting

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more realistic and gratifying interpersonal experience? If the first analysis is appraised by the patient as a disappointment, does he measure this in terms of time lost, money wasted, or as a personal injury? Does the need for a second experience in itself suggest a doubtful prognosis? What could the first analyst learn from the second, or the second from the first? What, if anything, can be learned from the patient about the first analyst: his idiosyncrasies, his technique, his theoretical convictions? Does the failure to remember ever mean that 'nothing happened' in the first analysis?

I need hardly interject the observation that data concerning all these questions, as offered by patient or analyst, are largely impressionistic. Conclusions derived from such data are hardly ever final or generally applicable. For example, the coterie of patients in a senior psycho-analyst's practice are affected by the fact of his seniority and presumed greater skill, by his selection of patients who can afford his fee or who can adapt to his preferred mode of practice, and the selection of him by patients who perceive themselves as either so hopeless or so worthy that only the 'best' will suffice. Such patients may be assumed to have more than the usual share of omnipotent strivings, ambivalent deference, and attitudes of ownership towards their therapist. They present a talent for more charm and elusiveness than most other patients, and more sophistication than most in the techniques of upper-class upmanship.

In an effort to limit areas for observations concerning the questions posed at the outset I have arbitrarily excluded from consideration in this paper (a) candidates in psycho-analysis, (b) patients referred by the first analyst after adequate preparation of both the patient and the second analyst, (c) those patients whose first psycho-analytic experience was of less than two years' duration, and (d) patients whose first analyst was not identifiable as a member of a recognized psycho-analytic institute. The patients to be considered therefore were those who had been treated with a high degree of professional competence by individuals accepted by the professional community as mature and experienced therapists, but who nevertheless disengaged themselves from their first experience, and after the elapse of a varying amount of time sought a 'second analysis'.

In addition, the essential dynamics and transference problems of patients will be categorized according to the predominant

characterological or neurotic defence which quickly became apparent in the second analysis and which proved to be relatively intractable and self-defeating in the first psycho-analytic experience, and frequently equally intransigent in the second. Despite the tradition of dealing with defence, a characterological or symptomatic defence may frequently be ignored or circumvented, and the essential goals of therapy may still be achieved. But the foremost defence indicates the character structure, the transference relationship that will develop, and gives clues to the genetic background.

I. Resistance to Transference Involvement

In the special circumstances of upper socioeconomic psycho-analytic practice the majority of patients seeking a second analysis remain aloof from transference involvement and seek to retain a phantasy that they are only observing and are always in control. There is indirect evidence of deep underlying anxiety which interdicts regressive dependency and may limit awareness of transference phantasy and affect. The compulsive intellectual defence is actively maintained, and there is a tendency for the second analysis to get into the same course as the first: an outwardly compliant patient who is basically unyielding in his resistance to the analytic compact or experience.

Such patients listen and respond intellectually. They are assisted primarily by clarification of the realistic basis for their tensions and frustrations, and the frustrations they impose on others. They cannot feel their hostility but logically deduce that it exists. They return to analysis because of the recurrence of depression, or from misgivings about their ability to control omnipotently their circumstances and their relationships. Their gains in therapy derive from clarification of such needs, from support of their efforts to rearrange their relationships and live in a more harmonious framework, and through their identification *while in analysis* with the point of view of the therapist.

They usually complain that their former analyst was without feeling, unrealistic in his interpretations, and biased in his theoretical convictions. They deny any hostility towards him, or even any degree of disappointment in the previous experience, but they insist that the former analyst must not be told that they have sought a second experience with a different analyst, lest the previous analyst 'feel hurt' by this evidence of their limited gains in the

experience with him. Charitably they insist that he was nice and kind, but that he was also basically inaccessible—a transparent projection of their own characterological defence.

In my experience, the most helpful approach has usually been one of direct support, together with realistic confrontation; but their masochistic needs are such that confrontation is felt by these patients to be a narcissistic hurt and results in a feeling of anguish and self-reproach, which more often than not seems of no profit to the patient, and usually flows out sadistically to those around him. Their significant gain in therapy appears to follow a diminution of their sadistic superego through identification with the more tolerant and realistic perspective of the analyst. (Clinically, these patients are usually categorized as aloof, intellectual, obsessive-compulsive individuals.)

II. Transference Idealization

The first analysis was terminated on the basis of an equilibratory pact between patient and therapist: 'Let us love and respect each other'. The termination of the first analysis had been characterized by reciprocal high regard, but by some doubt, usually not verbalized, on the part of both analyst and patient, whether either had been able to achieve or risk complete honesty in the relationship. The potential for intense anxiety and the impulse to 'act out' had been suppressed by maintaining the relationship at a level in which, at least in phantasy, reciprocal idealization seemed justified. There was evidence that underlying intolerable anxieties were related to phantasies of genital mutilation or castration which were sometimes manifestly evident in conscious masochistic phantasies, and in characterological traits and dreams which suggested strong underlying, ambivalent homosexual trends.

In the second analysis such patients sought to again establish an idealized transference, to find support in an effort to maintain and enlarge an idealized ego, and covertly to experience libidinal and narcissistic gratification in the friendly relationship with a patient, kind therapist.

Almost invariably in the second analysis, considerably more direct transference hostility was accessible. The patients disengaged themselves from the first analyst out of a disinclination to disillusion the kind parent and to avoid showing the parent the depth of their rage. Despite the seemingly good relationship which

existed when the first analysis ended, there was rarely any contact with the first analyst, or any inclination to refer spontaneously to him in the second analysis. Almost invariably they insisted that he must never learn of their displaced loyalty. Their situation was comparable to the child who leaves the parental home and thereafter in the main remains dissociated from his parents.

In my opinion, many of these patients are capable of basic characterological change in a second analysis, and the first analytic experience provides an opportunity for ego strengthening so that the patient could deal more realistically and honestly with the second analyst. Here, too, however, the analyst must be guided by the patient's tolerance for anxiety and the trend toward a sometimes obstinate depression when the self-deception is uncovered and the underlying pregenital strivings are revealed.

These patients may give the impression of intense interpersonal involvement, but they are basically narcissistic. They have access to their own feelings and enjoy awareness that others are involved with them, but they are themselves relatively uninvolved.

III. Chaotic Transference Reactions

These patients frequently give a history of more than one prior analytic experience. They introduce almost at once highly emotional, ambivalent transference phantasies. Their obsessional needs and their prior therapeutic experiences allow them ready access to 'unconscious material' and 'dynamic formulations'. They are eager to be analysed, and to demonstrate their aptness and sophistication as patients. Their immediate hunger is for approval, and this is sought by reiterated appeals for help, and by a preference for dwelling on their positive feelings for the analyst. They cannot experience a genuine analytic relationship just as they cannot tolerate a genuine intimate human relationship. If placed on the couch in a resumption of a classical approach, the effort goes on interminably. Free association, provides them with an opportunity for flight from, and resistance to, a realistic evaluation of their extravagant reactions to current experiences. They seek in the analytic experience a comforting and ego-sustaining refuge. Nothing may be really 'analysed', that is, nothing may be finally explored, resolved, and set aside. The availability of such a relationship appears to spare some of them from a psychotic dénouement

or suicide. Nevertheless, for some, a face-to-face realistic relationship which discourages the symbolic, and which insists on a continuing survey of the tension and frustration which they suffer and impose on others, disengages them from their infantile, sick self-image. They often profit from an early spacing of sessions so that regression is not encouraged, and from a long-sustained relationship which keeps in the foreground their capacity for real, if limited, relationships, and gives encouragement to their increasing capacity for rewarding and impressive creative work. The problem for the second analyst is actually to avoid 'more analysis'. He sometimes must disabuse these patients of conviction that 'more analysis' is necessary for their survival. (Clinically, such patients are usually categorized as borderline or potentially psychotic character disorders.)

IV. The On-going Analysis

In marked contrast, there are those patients who manifestly for external reasons must resume their analytic work with a second analyst. These are patients who have learned to use the analytic situation and have learned to work 'analytically'. The patient tends to act as if the second analysis is a continuation of the first. The second analyst, therefore, has to establish promptly the essential facts of the life history, the essential conflicts, and achieve an early understanding of the transference drama which the patient establishes almost as soon as he 'returns to the couch'. As a rule, minimal work is necessary on the current transference. A re-exploration of insights gained in the past work, as it relates to the current reality situations, and as it derives from childhood situations and conflicts, provides the main content of the psycho-analytic work. With such patients the second analyst carries on to a conclusion the first analysis, and termination is by mutual agreement, often in a relatively brief time, depending on the quality and duration of the previous work. Such patients ordinarily give clear indication of when they feel they have achieved their goals in the second analysis. Their judgement should ordinarily be viewed as realistic and not as a manifestation of 'resistance'.

V. The Transference Impasse of the Primarily Hysterical Patient

For most of us psycho-analytic work with the hysteric continues to be the most instructive of

all our psycho-analytic experience. The unconscious issues are dramatically portrayed in symptoms, in dreams, in the transference, and in the vivid and highly emotional recollections of early childhood strivings and conflicts. The enduring oedipal conflict portends a repetition of such problems during all later critical periods of development or interpersonal experience. Each new intimate relationship can be discouragingly analogous to earlier hopes and disappointments. The hysteric unconsciously makes each succeeding partner a disappointing parent surrogate. More often than not he models each succeeding choice on the likeness of the original, ambivalently loved and abandoned object. In his second analysis, he seeks to re-establish the seemingly irreconcilable issues which may have resulted in an impasse during the first analysis. From this group of patients I have chosen two who demonstrate the problem of the second analyst in avoiding a similar impasse, and his almost invariable need to modify his technique in order to keep in perspective the intense and confusing transference feelings which encumbered and brought to a halt the first analytic experience.

Case 1

Helen complained that her first analyst, with whom she had spent several years, was soft, ineffectual, indecisive, afraid of her, never evoked any clear, positive, or definite feelings, and always impressed her as more of an old woman than a man. He was, according to the patient, in many ways like her husband, who had exploited and criticized her for 20 years. Evidence of any appreciation was rare. He was dependent on her financially for many years of the marriage, but always acted like an insatiable tyrant who always took, never gave, and never acknowledged. Although a tyrant and feared, she felt that he was not really a man, but a dependent, small boy. The marriage was always tentative, and for 20 years she had been weighing its satisfactions in comparison with some idealized prospect. Curiously, the idealized prospects, in the form of transient, romantic, extramarital attachments, were always with sick, dependent, deprived, and ineffectual lovers.

Her first analyst, therefore, developed as another in a series of disappointing lovers. She felt, however, that her second analyst was definitely different, a wonderful man, etc. From the outset the second analyst attended to her effort at patterning this new relationship

according to previous relationships, such as the first analyst and her marriage. The work hinged on this repetition compulsion and its meaning. The last dream she remembered from her first analysis epitomized the final transference situation. In the dream she was 'vigorously chopping down a tall tree with an axe'.

It was unnecessary and undesirable to permit the same sequences to develop in the second analytic experience. It was necessary only to hold the patient to an awareness of her need to recreate the same ultimately dissatisfying neurotic relationship. It was unnecessary to explore regressively, in a second transference neurosis, the infantile conflicts and their symptomatic repetition. Data concerning these conflicts were abundantly evident as the first analysis was re-explored. The patient felt that she wanted from the analyst something which she felt able to give to her ten-year-old daughter: 'A big, comforting person'. Her own mother she remembered as an attacking, frustrating woman. She remembered how, at the age of 4, her mother discovered the patient's masturbatory activities and shamed and humiliated her. The rage with this mother provided grounds for angry disappointment in the father. She could retaliate only by a remembered wish to kill the baby brother or win the acceptance of the father, but mother and brother were always preferred and father always hindered gratification of her narcissistic, destructive strivings.

Like many patients who are natively, or neurotically, intuitive and introspective, this woman after several years of analysis did not need further 'uncovering'. She needed, instead, an integration of scattered or dissociated insights and painful affect. Initially the second analyst thought she had to work through her hostility to men. The patient corrected him and said, 'It will be no good if I have to fight and destroy you, too.'

The patient was treated face-to-face. The 'healthy ego' was appealed to for an exploration of relevant experiences in the first analysis. The therapist insisted that the patient see clearly the infantile defences and manipulations which had made the first analysis not a failure, but a stalemate. Reconstructing the first analysis, one had to assume that further work was impossible because of the caricature she had effectively established of her first analyst. Having chopped down her analyst, she could not risk expressions of tender interest in, or expectations from, the

injured phallic male. She had changed him into an ineffectual, feminine partner, and continued the romantic infantile search for, and flight from, the strong but feared father, who would accept with kindness the gentle woman. The patient was quite familiar with the concept of the analyst as an extension of the feared mother, but a continued preoccupation with split images and split affects would have continued her fears and anxieties. She required a period of work with an intact, accepting therapist, and not with a 'love object' in the transference sense, since this image re-evoked anxious longing, angry flight, and the sought-for refuge with a person perceived as an unaccepting mother. In the second analysis she disengaged herself from her traumatic childhood, and from the traumatic recapitulation of her childhood and the many endless fragments in the first analysis. As she herself put it, she required a person who would separate her from the 'mess of the past'.

Helen was disappointed in her first analyst because she modelled him as a weak, ineffectual, and dependent person. A variation of this theme, which is less often seen because of our increased alertness to the destructive intent of an erotized transference as a defence, is presented by a patient who was dismissed by her first analyst while still in the turmoil of 'love'.

Case 2

Mary came to her second analysis in a cloud of anxiety and desperation concerning the termination of her experience with her first analyst. Her previous therapist, even after several years, remained an idealized, cherished image. No superlatives were sufficient to describe this paragon; he was slim, dark, sensitive, kind—everything a woman would want in a man. He had injured her deeply, but she still loved him. Yet she could never tell him that she loved him, or why and how he had injured her.

The facts were, according to Mary, that her first analyst was in love with *her*. During the first phase of her second analysis she recounted her experience with the first, producing alleged evidence of his infatuation: the occasional smile, the courteous and gallant manner, his occasional sighs and sad demeanour, the hearsay rumours that perhaps all was not well in his own marriage, his note to her on the back of a calendar page given to her on Valentine's Day. All these bits of information, rumour, and gesture, she saw

as tokens of love to be stored in her heart and never, except through unwitting somatic repercussions, to be revealed in any manner to her analyst. Throughout this first analytic experience her husband had dwindled from a disturbing nuisance whose affectionate overtures were usually revolting, to a nonentity who had eventually been manoeuvred by her into his own analysis and then ignored. The endearments of her husband she described as cold, tentative, stilted, unimaginative, and repulsive. In contrast, the imagined caresses of her analyst were consuming, and although imagined, were more satisfying than the real efforts of her husband.

The first analyst was so involved with her, according to the patient, that he had consulted a colleague who decided that he was unsuited for classical psycho-analytic practice. She reported this to her second analyst slyly and with glee. Thus, as she seemingly kept intact her idol, she gradually demolished him. Her second analyst could only wonder whether in the face of all this smoke, there was not, indeed, some fire. Where was her first analyst during all this hot consummation?

Mary conceded that her first analyst undoubtedly saved her from either psychotic disorganization or some self-destructive impulsive resolution. Perhaps he was kind and accepting because he realized her deep feelings of inadequacy and unworthiness? But why, she asked, was he never more explicit about his feelings? And why had he allowed the accumulation of so much evidence which could only be interpreted as affection?

The description of her first experience clearly indicated the tactics necessary if the patient's confusion and residual intense ambivalent attachment could be finally acknowledged as indeed transference and not reality. There had to be a watchful lack of interest in any role other than analytic; explicit discussion of any happening in the relationship which might give the patient a chance to distort its meaning; a gradual dilution and dissociation of the patient from her distortions concerning the first analyst's predicament and from her attendant feelings of responsibility and guilt; the gradual and continual confrontation that the almost paranoid preoccupations concerning her first analyst were displaced reaction formations from anxieties concerning an earlier incest object; and, hopefully, an eventual acknowledgement that her disappointment in her husband derived not only from a compulsion to castrate him, but to

establish him as a mother who would be tender, understanding, supportive, undemanding, and asexual.

Her husband, responding to these needs, became, in fact, such a person. He ceased making sexual demands, or having sexual expectations. They became good friends. His own career flourished as he gave up the frustrating effort to be accepted as a husband, or to view his failure to meet his wife's needs as evidence of his failure as a person.

The second analyst never quite achieved his hoped-for goals. The patient gradually disengaged herself from her excessive preoccupation with the first analyst. The second analyst was established as a firm, tolerant, but never altogether trusted father. Her husband sturdily, and perhaps masochistically, resigned himself to his limited and symbolic role in the marriage. Although the patient's basic hunger and anxiety had homosexual determinants, the patient was by this time a middle-aged woman, and because of her definite recovery from her transference neurosis it was considered inadvisable to tamper with a basically fragile ego.

Curiously, during an interruption of the second analysis, the patient found a lover, and in some respects made her greatest gains during this experience. He was marginally employed, middle-aged, passive, tender, and sexually adventurous, and made the patient feel womanly and adequate. She handled this 'other life', as she called it, with great discretion, and gave up any further real interest in either her first or second analyst. She found external reasons, as well as subjective ones, for discontinuing the second analytic experience, when the second analyst suggested that perhaps more work was needed on the meaningfulness of this extra-marital relationship.

The first analyst felt he was dealing with a schizoid and unstable individual whom he treated with tact and gentleness, which was interpreted as 'love' by the patient. The second analyst's primary concern was the near-psychotic furor with which the patient terminated her experience with the first analyst. The patient's own solution was to stabilize her needs and her world by a frigid relationship to the husband, a dependent relationship with her second analyst, and a warm, protective relationship to a lover, a solution which is perhaps more common than we analysts (with our idealized goals and Calvinistic morality) acknowledge.

In most of these patients, admittedly a select group, the first analytic experience altered inevitably their attitude toward their second. Their expectations were more limited and more realistic. Most observed early in the second experience that 'I know now there is no magic in this, and that most depends on me'. Most were able to be specific about what they sought in further analysis, the problems that were insufficiently understood, the attitudes towards work or relationships which required modification. Some introduced the prospect with the reservation that they intended to devote only a limited amount of time to the second endeavour. The two patients I have described pointed to the couch and said, 'I never want to go through that again. I want you to stay *real*.'

I could not find evidence that those patients who presented themselves in a muddled obsessional state, ambivalent, disappointed and hurt by their first experience, were indeed damaged in this way by their first analyst. I felt certain that they had presented themselves in a like manner to their first analyst, and that this interpersonal approach was characteristic of them in prior dependent relationships.

There is the occasional patient who after many years of hopeful effort is dismissed as unsuitable for further psycho-analytic work. Their resentment is not unjustified. One would have hoped that in these instances our colleagues had not been so tenacious or doctrinaire. The patient suspects that his own perseverance and loyalty to the work has been exploited. When the psycho-analytic work bogs down, consultation with a colleague is always helpful. On occasions I have asked a colleague to see such a patient. The patient experienced this as realistic and helpful. Early assessment of poor prognosis and a decision to terminate or transfer leaves the patient less hurt emotionally and financially, and sometimes spurs him into a second endeavour which is more profitable.

Except for patients who have been 'over-treated' it has not been my experience that a first analysis complicates or handicaps the second analysis. The second analyst can arrange his technique and goals according to evidence from the patient's first experience. One is not, as the patient fears (or wishes), in the position of having to 'start all over again'. If indeed this is the case, then the second analyst may well consider the advisability of not starting at all, or at least of limiting sharply his own and the patient's expectations. Even when the patient has little if

anything to say about the first analysis, one can see in the early hours a recapitulation in the transference of the essential developments, or resistances, in the first analysis.

In my experience there is often no need or advantage in developing an 'analytic situation', with 'intensity' and 'frequency', and a renewed transference involvement with patients who have already had years of analysis. The patient's needs are best served if both patient and therapist realistically review the reasons for the patient's return, the meaning of his past experience, its possible relevance to on-going and current problems. Further exploration in an arrangement encouraging 'transference' is always possible after face-to-face study is finally considered as offering insufficient information.

Do any counter-transference attitudes emerge as an occasional interference with the patient's efforts? I would rate first as most frequent, *moralistic attitudes in the analyst* which convey disapproval, or actively interdict experiences, for example, 'acting out'. Sometimes there is no better way to unglue the defensive rigidity of a patient than to allow him to experience a little social difficulty or sexual mischief. There is occasional evidence of rigidity in analysts which is not necessarily characterological but is pedagogic in origin. I have even heard that a Psycho-analytic Institute forbade its candidates to hear a paper on 'Pornography and Psychotherapy'.

There is evidence in some analyses of a degree of activity which suggests that the transference provides a setting for the analyst's histrionics rather than for the transference drama. In the main, however, most patients observe, regarding their former analyst, 'He never said anything'.

Finally there is suggestive evidence that inevitably the analyst's personal value judgments affect the analytic work. Some analysts have conceptions as to how the analysis *should* go and the sort of person the patient *should be*. Usually this is in the direction of creativity, productivity, and marital fidelity.

How meaningful are we to our patients? Almost none of these patients gleaned any information about the analyst's personal life, theoretical convictions, political affiliations, etc. All analysts succeeded in withholding any real data concerning themselves, or if they revealed any, they were not sufficiently important for the patient to remember.

Only real people and real relationships are meaningful. Analysts are shadows and symbols.

I have never been impressed by evidence of termination grief at the prospect of loss and separation from the analyst. Such grief appears to me as evidence of residual transference longings and anxieties. Our patients want us to stay well as long as they need us. What happens to us thereafter seems of no special moment to them. I dealt with two patients who were referred after their analyst died. There was certainly some evidence of anxiety and feelings of abandonment. But these were not tears shed for the loss of an important object; they were tears of self-concern and self-pity.

The situation is different when an analytic relationship evolves into a real friendship. Our anonymity has indeed demonstrable usefulness. But an essential experience is lost to the patient when such anonymity is always maintained. As the patient Mary, who thought her analyst loved her, frequently said: 'He never allowed me to be a person, or allowed himself to be a real person with me. Even years after I was no longer his patient, whenever I met him he took the doctor role. I felt he rejected me as a real person and accepted only the patient. Perhaps he was afraid of real contact with me.' I believe that during the later months with him was due to her need finally for experience and acceptance by the analyst as a person, rather than as a neurotic, transference-involved patient. The second patient, Mary, discontinued her first analysis after five years *without ever having looked at her analyst*. Some analysts maintain a degree of detachment and reserve which helps to convince the patient that he is only a construct of defence and impulse, and that when these are analysed he is nothing else that interests the therapist. Some patients need conviction that they are meaningful beyond their participation as patients. We cannot always assume that the patient's frustrations originate altogether from unfulfilled transference longings. Some of the most conclusive analytic work I have seen was in cases where doctor and patient became friends and colleagues, and perhaps occasionally used each other not as therapists, but as concerned and interested friends.

How tenacious is the transference involvement with the former analyst? Hardly at all if there is a new transference object available. Transference is maintained out of hope for transference gratification, and when the patient is finally convinced that this is not possible, transference evaporates. Residual and enduring vindictive

feelings toward the former analyst may indeed keep transference involvement active, but in two cases where this was evident the patient's bitterness appeared to have considerable realistic justification.

What of those cases where transference appears not to develop, where the entire work was primarily 'ego analysis'? Transference always develops, even though it does not become overt and accessible as part of the working relationship. Nevertheless, I cannot say that these patients profited less than those who developed transference involvement and transference neurosis. Analysts appear to have a 'transference bias'. If the patient doesn't 'buy it' we assume there is resistance and we aren't getting anywhere.

Summary

Of twenty-two patients I considered six as primarily intellectually defended individuals whose involvement in any overt transference interreaction was negligible. Three of the six had had more than one prior analytic experience, and of these I learned that two in later years arranged for additional analytic work. These were all individuals of considerable attainment who returned to analysis at the insistence of their spouses with renewed feelings of depression and discouragement.

Four patients presented chaotic transference interaction, and all came for additional analysis out of feelings of desperation and isolation. Two of these arranged for additional therapy in later years. One required electroshock therapy shortly before his death at the age of 58.

Eight patients I considered as seeking to maintain an idealized static transference relationship, and succeeded pretty much in maintaining this façade through most of the second analysis. Most of their hostility was directed towards their former analyst. Of these four, three had been in psycho-analytic therapy more than once previously, and two went on for further work in later years. One of the latter patients who terminated with me after great protestations of appreciation and friendship, quite as she had terminated with her first analyst, later described me to her third analyst as also a hypocrite and scoundrel.

Four patients came with a preference for the type of hysteric involvement described in the cases of Helen and Mary. One of these wrote me in later years, after marriage and several children, for suggestions regarding further analytic work in a distant city. With these four patients I felt

more had been achieved in terms of emotional stability and growth, and a capacity for reciprocal honesty, than with the other eighteen.

Several colleagues have questioned the appropriateness of considering a second experience a 'second analysis'. A number of these patients could never become involved in an analytic situation where transference awareness is the primary learning experience. 'Psycho-analytic therapy' has been suggested as more descriptive of the technique required in these instances. Also, some patients seek a second analyst to understand and conclude their previous analytic experience. The analysis of the first psycho-analytic experience constitutes for some the main work of the second experience. But when in most cases there is a *different beginning*, a *different course*, and a *different ending*, I have felt that the rubric 'second analysis' was applicable.

I wish to emphasize that for most of these patients there was no justification for considering the first analysis a 'failure'. In most cases all that could be elicited through further transference involvement, through exploration of unconscious fantasies, and the essential genetic facts, had been uncovered in the first experience. An unusual degree of defensiveness, primarily denial, had made acceptance and consolidation of the prior experience impossible without a change in analysts.

I have suggested that in most of these patients the experience of transference was unacceptable, and that if any technical error existed it derived from the first therapist's insistence that the patient work '*analytically*' and accept the reality of the transference. As one patient said in retrospect: 'The man was utterly unrealistic in demanding that I trust him. The prospect of abandoning myself to this degree of trust

provoked in me a feeling of panic and I could only remain silent.'

In classical analysis a degree of trust and intimacy is required which may be beyond the capacity of some patients, and the analyst need not feel that his contribution and effort is thereby diluted or modified. Our primary goal is to assist the patient in finding relief from his symptoms and in lessening characterological rigidity. We cannot too resolutely insist that the patient fit into the familiar pattern of transference regression and resolution. We are only too familiar with patients who are 'well analysed' but are finally most comfortable with characterological traits and interpersonal safeguards which impress others as idiosyncratic or peculiar.

Finally I have referred to the occasional absence of real and meaningful relationships between patient and therapist even at the conclusion of a long therapeutic effort. Sometimes this is consequent on a patient's need to maintain distance even from the person in whom he has placed his greatest trust. But in some cases the analyst's conviction that the analyst is always an *analyst*, and that the patient is always a *patient*, deprives both therapist and patient of the basic enriching and gratifying experience—a meaningful human relationship, mutually shared, unencumbered by neurotic limitations or concerns. The final relationship should be real, genuine, and capable of enduring mutual criticism and acceptance. Perhaps the most appropriate comparison is to the maturation of a child-parent relationship. The child becomes the adult, independent, free to judge the parent objectively, and secure in the knowledge that the parent sets no conditions on such judgement or such freedom.

A NOTE ON MIGRAINE

By

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The patient who helped me to understand her defensive use of this complaint and, by so doing, greatly lessened its severity in her, had long suffered, intermittently, from a typical form of it. That is to say, the attacks began with a sense of partial blindness, as if her view were obscured by a dark area, after which jagged, blinding lights appeared, and ended, after these had gone, in an acute headache which gradually wore off.

It had already become apparent, during the course of some years of analysis, that the migraine was affected by psychological factors, and, in particular, that it tended to become worse whenever the analysis itself was felt as, in a high degree, emotionally disturbing. I had once suggested—on what grounds I am afraid I no longer remember—that she felt her migraine to be analogous to the blinding light St Paul saw on his way to persecute the Christians and that it was therefore related to her own unconscious sadistic phantasies. But this was all I could discover, or guess at, until a particular dream gave a much more specific clue. This followed a period of unusually frequent and severe attacks during which she had been trying to face, and adjust herself to, an actual calamity in her life. In the dream, 'she was outside her own house. Her mother (who does not, in fact, live with her) was inside and calls her in. She goes in, with strong feelings of love (such as she could hardly remember actually feeling for her mother.) Her mother is bending down by an electric wall plug, and seems to be small. But then she becomes small, too. Her mother looks at her and says she cannot bear the terror in her eyes. Then she looks down and, to her horror, sees that her mother is about to electrocute her with two wires.'

All I could at first see in this was a link with a dream of the previous night in which 'she had been able to tell a woman, who was symbolically in the relation of a mother to her, about the actual calamity (I mentioned).'

In fact, she had found it almost impossible to

speak to anyone about this, though I felt both dreams reflected an increased ability to do so to me. I also noted in the incident about first her mother, then also herself being small, a characteristic confusion between herself and her mother as to who was the mother and who the baby. At the end of the session, I felt that the dream had been important, but was disappointed at having discovered so little of its meaning.

The next session began with my patient's being silent, and appearing to be resentful. I suggested this could be because she felt I had missed an opportunity to understand the dream. She then gave more associations to it. In particular, the electric wires reminded her of a curious object in an earlier dream of three nights before: 'a thing, like a fishing rod with a lump like an electric switch on it, seen lying under her damaged car, which seemed to have been torn away from the trafficator lamps.'

It then occurred to me that these torn off trafficator wires represented her optic nerves which she felt her internal mother had burnt out in order to protect her from seeing something terrifying. She was immediately convinced by this; and further confirmation was provided by the prolonged disappearance of the migraine—which has not returned, though of course I cannot guarantee that it will never do so. (In retrospect it seems possible that the fishing rod with the torn wire attached represented a 'rod' from the retina. It is not, of course, suggested that her infant-self knew anything of optic nerves or rods and cones. But she did seem to be using her adult knowledge to form a dream-model of an early pattern of emotional experience which had remained unmastered because she had never been able to begin to express it in symbols. That this can be a function of dreams is an idea I owe to W. R. Bion.)

The next problem was to discover what it was which, apart from the actual calamity, was unconsciously linked with it and too terrifying to be seen. Another dream, about ten days later,

threw some light on this. 'She is driving her car away from a house. There is a wall on the left and, on the right, a green van parked well on the verge. A sports car is approaching and she slows down. But although there is plenty of room for it to pass between her and the parked van, it swerves away from the van on her right, across in front of her, and crashes into the wall on her left. A young man gets out; his eyes are mad, sightless, and glazed; he staggers over to her car and attacks her headlights with an enormous spanner.'

Here, again, is the attack on the eyes—both his and her own—represented by the headlights of her car. Furthermore, from the pattern of the accident, I suggested that it looked as if it had occurred because the young man (already familiar as her imaginary male twin) had seen something in the parked green van which she had not. She then remembered that the green van had appeared in an earlier dream about two months before, just after the actual calamity I spoke of. In that dream: 'the green van had been parked and a pack of hounds had poured out of it, each wearing a red coat as if they were huntsmen . . . There had also been an accident involving three cars in this dream; and she had been afraid the ambulance or fire-engine, which was coming, would run over the hounds as they crossed the road . . .'

It seemed probable, then, that what the young man had seen, and she had not, in the green van in the recent dream was linked with the red-coated hounds in the earlier dream. I suggested that the hounds which 'poured out' were faeces, that they were red because they were bloody, and that this represented the evidence of an internal calamity, probably to me as her internal mother. I also tried to link this with the miscarriage her mother had had in her infancy. However, there did not seem enough evidence to substantiate this at the time; and she, though thinking it plausible, did not seem to be emotionally convinced.

Meanwhile, as she had lost her ability to have migraine, other defences against the full perception of what I thought was an internal event began to take place. For instance, about four months later, I think after I had interpreted some oedipal material and used the word 'murder' in a way which had aroused in her an unusual sense of horror (unfortunately my notes are incomplete on this point), she arrived at the next session feeling quite disorientated. She told me she had dreamed that 'she was sitting

where I sit, trying to show a book of paintings to three women: one who could hear but not see, one who could see but not hear, and one who couldn't remember . . .'

It seemed clear that she had split herself in this way in order not to apprehend the full horror of the situation illustrated in the book.

Moreover, I got the impression that, like some patients described by Bion, her oedipal phantasies had been, and were being, split up before they developed. I felt as if she were requiring me to act as her imagination and tell her how her phantasies would have developed if she had been able to develop them. From the beginning there had been intermittent, and quite conscious, anxieties about accidents I might have at weekends in my car, which I had done my best to interpret as they arose. There had been persistent, but also scattered, references to car accidents seen, but not heard, in dreams, and waking experiences of noises associated with screams heard, when their cause was not seen. From these I constructed a more vivid picture of what I thought one phantasy, if it had not been disrupted at its inception, would have become: a phantasy of an accident to the car in which I was imagined to go off with my wife and children for the week-end and that she would both see it and hear the screams. There was also evidence, from the intensity with which she seemed sometimes to listen for noises inside her body, that all this was felt to take place inside her, when her unconscious rage with me for leaving her was at its height. This, or something like it, seemed to be the horror in the green van—ultimately her envious self—against the apprehension of which she had originally protected herself by the migraine. (I also thought it had been hiding behind the actual calamity she had been unable to speak of.) She emotionally felt this interpretation to be right and experienced relief.

I should add that the greater integration she then achieved enabled her to be more aware, not only of terrifying phantasies, but also of good ones. On the next night she dreamed that my consulting room was an art gallery containing two objects of extraordinary beauty.

In this note, I have tried to isolate and follow one thread—that of migraine—among many others interwoven with it. I am aware that I have done so very incompletely. I do not think I should have got on to this particular thread at all, but for the two dreams that made it obvious. Retrospectively, it became obvious that the

migraine thread had been present in many earlier dreams, and other material about blindness in various forms, which I had not understood at the time. I have no evidence on which to justify a general theory that everyone

with a constitutional liability to migraine would be likely to use it in the same defensive way. All I claim to have established is that it can be so used.

EVALUATION OF MELANIE KLEIN'S 'NARRATIVE OF A CHILD ANALYSIS'¹

1. By

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Introduction

Melanie Klein's last work was published shortly after her death in 1960. Her way of working and thinking could not be more thoroughly revealed than in this case history of a ten-year-old boy, *Narrative of a Child Analysis*.¹ Her concepts and their application in psycho-analytic work have led to a special school—the so-called English School of psycho-analysis. Her theories differ from the traditional viewpoint less in content than in emphasis and in the chronology of the child's development—e.g. the dating of the Oedipus complex, the formation of the superego. Some of her theories, however, such as the concept that in early mental life the child passes through psychotic phases, are accepted only by the Kleinian school.

To do justice to this record of a child analysis and to understand more fully the rationale of Melanie Klein's way of working, a brief review of her theories, especially as they apply to psycho-analytic technique, is appropriate. This part of the review is not intended to be polemical. A chronological account of her concepts and an attempt to contrast these with the Freudian concepts of child analysis is more in order for this particular purpose.

Throughout Melanie Klein's clinical papers of the 1920s, we find observations which led her to the development of her play technique, the principles of which are still applicable and are today an integral part of analytic work with children, especially young ones. She soon came to the conclusion that a child in analysis, like an adult, needs sessions of consistent frequency and duration. Since a child's verbal communications are insufficient, Mrs Klein provided toys and play material. She scrutinized all the activities of the child, e.g. his particular choice of game, his fantasy play, etc., not only as to content but also as to how it was reported,

modified, interrupted, and so forth. She became aware of resistances and also of the importance of the person of the analyst in the transference relation for the child. In her work with younger children, she soon discovered evidence that the beginning of oedipal strivings appeared in young children earlier than the fourth and fifth years, where reconstructions from adult analysis had placed them. She elaborated upon this in her paper of 1926, 'The Psychological Principles of Infant Analysis'. In her work with a four-year-old girl who had suffered from pavor nocturnus at age two, she observed that this child would attack her physically and then retreat to the corner of the couch, crouched in the same position she had adopted in bed when she began to suffer from the pavor nocturnus. The pavor nocturnus turned out to be closely linked to oedipal fantasies. This bold concept of Melanie Klein's, which contributed much to our knowledge about early development as well as to our methods of working analytically with children, then became the cornerstone on which she erected her far-reaching hypotheses.

In the same paper, in 1926, she wrote in a footnote (page 141):

'In a number of children's analyses I discovered that the little girl's choice of the father as love-object ensued on weaning. This deprivation, which is followed by the training in cleanliness (a process which presents itself to the child as a new and grievous withdrawal of love) loosens the bond to the mother and brings into operation the heterosexual attraction, reinforced by the father's caresses, which are now construed as a seduction. As a love-object the father, too, subserves in the first instances the purpose of oral gratification . . .

'I think that the effect of these deprivations on the development of the Oedipus complex in boys is at once inhibitory and promotive. The

¹ Published by the Hogarth Press and the Institute of Psycho-Analysis, London, 1961. Pp. 496 + 74 plates. 75s.

inhibitory effect of these traumas is seen in the fact that it is they to which the boy subsequently reverts whenever he tries to escape from his mother-fixation and which reinforce his inverted Oedipus attitude.'

She continues:

'The circumstance that these traumas, which pave the way for the castration complex, proceed from the mother is also, as I have seen, the reason why in both sexes it is the mother who in the deepest strata of the unconscious is specially dreaded as a castrator.' [Fantasies about the phallic and pregenital mother were described by many workers in the 1920s, especially Fenichel.]

'On the other hand, however, the oral and anal deprivation of love appears to promote the development of the Oedipus situation in boys, for it compels them to change their libidinal position and to desire the mother as a genital love-object.'

This idea is then again elaborated upon: 'The boy, when he finds *himself impelled* [italics mine] to abandon the oral and anal positions for the genital, passes on to the aim of penetration . . . ' etc. ('Early Stages of Oedipus Complex', 1928).

Or another formulation, from 'Criminal Tendencies in Normal Children' (1927), where Mrs Klein reveals her gradual departure from the classical analytic concept of libidinal development:

'A child in the 2nd year of life has gone through its oral fixations', and a little later: 'in the first year too, a great part of the anal-sadistic fixations take place.' So stated it seems that a fixation is a stage of normal development, whereas psycho-analysts consider a fixation a result of disturbed development relatively due to either too much frustration or over-stimulation—relative because this depends either on strength of the drives or on environmental influences and their interactions.

Many of Melanie Klein's clinical observations are astute and accurate. But the vicissitudes of the libido that occur in some cases as a result of frustration and trauma were developed by her into a general theory of libidinal development. Furthermore, one finds in her descriptions implications that a child's ego possesses the ability to manipulate maturational or inter-systemic processes.

It was, however, to Mrs Klein's credit that she observed as early as the age of two the death wishes to unborn and newborn siblings, the castration fear, the budding oedipal strivings,

the reactions to the primal scene and the anxiety and guilt reactions. But she sees this anxiety and guilt at age two as a result of a fully established superego, rather than as a reaction of the ego motivated by fear of the loss of the love object, in this instance a nucleus and forerunner of the later superego. She writes:

'In the cases which I have analyzed the inhibitory effect of feelings of guilt was clear at a very early age. What we here encounter corresponds to that which we know as the superego in adults . . . ' which she explains as follows: The analysis of very young children shows that 'as soon as the Oedipus complex arises they begin to *work it through* and thereby to develop the superego'. The term 'working through' is used as a maturational term rather than as pertaining to technique.

Melanie Klein describes the fore-stages of the superego as if they were the superego, which Freud conceived as a definite structure, the development of which (in its moral concepts and ideals) is gradual and formed by the end of the Oedipus complex, roughly at age six.

In the same paper of 1926, Melanie Klein deals with the problem that in certain children the excessive guilt feelings seem out of proportion to the mildly restrictive attitudes of the parent. She introduces the concept of the *introjected* parent, rather than a fear on the child's part of losing the *real* parent. These introjections, which in the early papers she also refers to as identifications, become in her later theories total absorptions within the ego, which torment, persecute, are expelled, and, from her descriptions, have a demoniacal character.

Melanie Klein brings a case of convincing material of a three-year-old girl who wanted an elephant next to her bed. This elephant was supposed to prevent a baby doll from getting up, otherwise it would steal into the parents' bedroom and do some harm or take something away. The elephant (a father imago) was intended to take over the part of the preventor. ('Personification in the Play of Children', 1929).

'This part of the introjected father had filled within her since the time between the ages of 15 months to 2 years when she had wanted to usurp her mother's place with her father; . . . Rita was inwardly playing both parts, that of the authorities who sit in judgment and that of the child who is punished.' But somewhat later she refers to this as 'a fundamental and universal mechanism in the game of acting a part [which] serves to separate those different *identifications*

at work in the child which are tending to form a single whole.' Thus the reader wonders why Mrs Klein calls the same mechanism at one time an introjection, and at another an identification.

She continues: 'By the division of roles the child succeeds in *expelling* the father and mother whom, in the elaboration of the Oedipus complex, it has *absorbed* into itself and who are now tormenting it inwardly by their severity.'

When reading this, one may raise questions as to the wording of the statements and feel confused. But these loosely written, somehow not quite logical statements, will suddenly a few years later reappear as facts to support her hypotheses about early development.

In the paper, 'The Psychological Principles of Infant Analysis' (1926), Melanie Klein comments for the first time on the ease with which unconscious fantasies are available to the young child. Children produce such material with pleasure and in great variety; and she states that interruptions in its flow occur because of resistance produced by the sense of guilt. She then continues about how children in their play represent symbolically fantasies, wishes and experiences and are fully under the dominance of the repetition compulsion: '... they are employing the same language, the same archaic phylogenetically acquired mode of expression as we are familiar with from dreams. We can only fully understand it if we approach it by the method Freud has evolved for unravelling dreams. *Symbolism is only a part of it* ...'

It is again to Melanie Klein's credit to have discovered the discharge in play and in sublimation of masturbation fantasies. She says: 'this underlies all play activity and serves as a constant stimulus to play (*compulsion to repetition*).' Here again, unfortunately, a distortion appears which later on will lead to an erroneous concept of the repetition compulsion. Also, by such a statement she reveals her lack of interest in the developmental biological function of play which is characteristic for mammals of a higher order.

In her contribution to the 'Symposium on Child-Analysis' in 1927 she elaborates on this observation. She makes a statement which has a profound influence on her analytic technique:

'We can establish a quicker and surer contact with the Ucs of children if, acting on the conviction that they are much more deeply under the sway of the Ucs and their instinctual impulses than are adults, we shorten the route which adult analysis takes by way of contact

with the ego and *make direct connexion with the child's Ucs*. [Italics Klein's.] It is obvious that, if this preponderance of the Ucs is a fact, we should also expect that the mode of representation by symbols which prevails in the Ucs would be much more natural to children than to adults, in fact, that the former will be dominated by it. Let us follow them along this path, that is to say, let us come into contact with their Ucs, making use of its language through our interpretation. If we do this we shall have won access to the children themselves. Of course this is not all so easily and quickly to be accomplished as it appears; if it were, the analysis of little children would take only a short time, and this is not by any means the case. In child-analysis, we shall again and again detect resistance no less markedly than in that of adults, in children very often in the form still the more natural to them, namely, in anxiety.

... Only by *interpreting* and so *allaying* the child's anxiety whenever we can reach it shall we gain access to his Ucs and get him to *phantasy*. [Italics Klein's.] Then, if we follow out the symbolism that his phantasies contain, we shall *soon see anxiety reappear*, and thus we shall ensure the progress of the work.' [Last italics mine.]

Here Melanie Klein reveals a duality in her thinking: on the one hand a free communication between unconscious and conscious, and on the other the need to lift the repression. That anxiety in its many disguises is either allayed or reappears owing to symbolic interpretation can have many meanings. It can be truly allayed owing to correct *timing* of the interpretation, i.e. after sufficient analysis of the resistances. But how, when anxiety reappears, does Mrs Klein know whether it is due to the progress of the analysis, or to the anxiety which the direct symbolic interpretation has aroused in the child?

Furthermore, the impact of an adult who suddenly talks freely in this way may be highly anxiety-provoking as well as seductive. This, in turn, produces increased anxiety, due to the excitement created by such talk. How then does an analyst know after such a symbolic interpretation whether the guilt which ensues is not a result of this, rather than a sign of progress of the analysis?

And when Melanie Klein states that the symbolic interpretation leads the child to fantasy, how does one know whether he does this to

please her or because children learn from adults and try to be like them as a normal developmental trend to becoming adults? If the adult talks like this, why should the child not take it over as part of his normal learning process? But also very soon, from adults' reactions, be they directly prohibitive, or from their reactions as they are expressed in a more controlled way (see Burlingham's paper, 'Die Einfühlung des Kleinkindes in die Mutter', 1935), children have learned that talk about sexual and anal matters is forbidden and exciting.

And then Mrs Klein adds in the next paragraph—correctly, in my opinion—'This, then (the resistance) is the second factor which seems to me so essential if we wish to penetrate into the child's Ucs. If we watch the alterations in his manner of representing what is going on within him (whether it is that he changes his game or gives it up or that there is a direct onset of anxiety) and try to see what there is in the nexus of the material to cause these alterations, we shall be convinced that we are always coming up against the sense of guilt and have to interpret this in its turn.'

In 'Early Stages of the Oedipus Conflict' (1928), Melanie Klein advances the Oedipus complex to 'about one year of age'. This is at the height of the stage of oral-biting; 'thus the child wants to destroy its libidinal object by biting, devouring and cutting which leads to anxiety, since awakening of the Oedipus tendencies is followed by introjection of the object, which then becomes one from which punishment is expected.'

(This very important statement, which becomes the basis of all her later theories, is *nowhere* proved by analytic material but deduced from symbolic translations.)

To continue: 'The connection between the formation of the superego and the pregenital phases of development is very important from two points of view. On the one hand, the sense of guilt attaches itself to the oral- and anal-sadistic phases which as yet predominate; and, on the other, the *superego comes into being while these phases are in the ascendant, which accounts for its sadistic severity.*' [Italics mine.]

Here we see that the beginning of the Oedipus complex is pushed forward some more. In addition, the libidinal development is portrayed in a way that is belied by observations on the development of infants and toddlers. It is true that some overlapping takes place, e.g. the oral biting stage is waning when the anal stage

begins to ascend. When fixation has occurred in the oral phase, the oral component will continue to exist in stronger form. But it leads to confusion to conceptualize all libidinal stages of development as occurring simultaneously.

One of Freud's most important discoveries was that what is unconscious later is even unconscious in childhood, although some fluctuations in the degree of awareness of unconscious processes do exist. Resistances have to be overcome, even in childhood or adolescence, to bring unconscious phenomena to consciousness.

Mrs Klein's contribution to the 'Symposium on Child Analysis' (1927), which had as its purpose the discussion of Anna Freud's book, *Introduction to the Technique of the Analysis of Children* (1926), served as a clear exposition of Mrs Klein's technique of the analysis of children. Many of her criticisms of Anna Freud's work are valid today: e.g. the manipulative preparation of the child for child analysis as then proposed by Anna Freud is outdated. A systematic analysis of the defences and affects has taken its place.

When one reads the papers in which Mrs Klein discussed her technique versus Anna Freud's without demonstration of clinical material, much of what she wrote still holds today. Only in her clinical work do we see the use of too many premature id interpretations, and an exaggeration of what she considers to be the transference relationship. Mrs Klein overlooks that the immature ego of the child cannot form a complete transference like the adult's. The child analyst has to take into account the fact that a certain amount of fear of strangers is real and not transference; that a need for dependence on an adult is not transference but inherent in his stage of development. Also the assigning of role-playing to the analyst is not in itself a transference but is characteristic of the play of children. That at times it has transference implications is true, and at times the assignment of a role to the analyst has a specific meaning which needs analysis. To translate the role-playing directly into transference is to disregard the fact that the child's ego is different from the adult's ego. The child analyst has to take into account at all times the level of ego development with which he is dealing.

The *Narrative of a Child Analysis* reveals the difference between the two schools as far as analysing the defences is concerned. Richard, the ten-year-old boy, is very preoccupied with the

war situation. He keeps careful track of what is happening in the various countries and immediately in his first session talks about Hitler, the Poles, the Austrians. He also asks whether Mrs Klein is an Austrian. He goes on to mention his fear that a tramp may kidnap his mother. Mrs Klein then asked whether he knew the meaning of the word 'genital'. Richard first said no, then admitted that he thought he knew. Mummy had told him that babies grew inside her, that she had little eggs there and Daddy put some fluid into her which made them grow. Consciously he seemed to have no conception of sexual intercourse or a name for the genitals.

In a footnote Mrs Klein added that she had asked Richard's mother about the expression he used for genital and was told that he had none and never referred to it. Mrs Klein then interpreted that when he was frightened at night Richard might fear that Daddy was doing harm to Mummy. When he thought of the tramp he did not remember that Daddy would protect his mother because he felt that Daddy might hurt Mummy. Thus, in careful wording, Mrs Klein here interpreted the primal scene to him.

Representatives of Anna Freud's school would have considered it pertinent to discuss with him at this point his fear of bombs, of Hitler, of the Austrians, and verbalized with him his concern whether Mrs Klein was an Austrian like Hitler and maybe a Nazi, or an oppressed victim of the Nazis. This approach would add further clarification of the patient's preconscious and unconscious thoughts as well as providing a means to observe in detail his methods of warding them off. One would also in this way verbalize with and for him his fear of and concern for the analyst. This can be considered as an introduction to later transference interpretations dealing with his love for and fear of women. One also wonders about the procedure of referring to sexual material before the boy had in some way or other brought any ideas or dream material about it; especially when alerted by the fact that the boy did not even have a word for genital, *as far as his mother knew*. [Italics mine.]

Melanie Klein's questioning of Anna Freud's work of 1926 about transference was valid. Children develop many more transference reactions than Anna Freud stated in 1926. But it cannot become a complete transference, as Mrs Klein assumed, because the ego and the superego of the child differ in many respects

from the adult ego and superego. Also the child is still emotionally dependent on his love objects. Although she is right in stating that a child's ambivalence towards his parents can be analysed, nevertheless one cannot carry out an analysis if the child's parents are not emotionally ready to tolerate his analysis.

To determine what is transference and what is a normal childhood reaction is an integral and continuous function of the analyst. Thus not every action in which the child talks about or reacts to the analyst is transference. It is the case to a far lesser extent than in adult analysis. In child analysis the analyst has constantly to assess the child's ego development, not only for the wording of his interpretation but also for a total understanding of the child in the analytic situation.

Many papers of the 1920s showed a tendency to personify the psychic structure. Freud himself in his paper on 'Mourning and Melancholia' writes that the 'shadow of the object has fallen on the ego'. Rado speaks of splitting up the mother-image into a good and a bad mother. But Melanie Klein uses the descriptions in metaphorical, sometimes poetical language to explain analytically the child's play. She will interpret that the superego is persecuting the ego if the child plays out a beating fantasy, or that the characters in the doll play of a little patient 'embody the id and the super-ego'. And when one character of the doll play spies upon or tortures the other one, she infers that the child has a paranoia and the superego is persecuting the ego or the id.

In the paper, 'Personification in the Play of Children' (1929), Melanie Klein gives clinical examples of these personifications introduced by children in their play. She discusses the case of a 6-year-old girl, suffering from a severe obsessional neurosis, which, according to her, masked a paranoia. The diagnosis paranoia derived from the fact that the child in its fantasy games had Melanie Klein spied upon, people divined her thoughts, and the father or teacher allied himself with the mother against her—Melanie Klein 'was always surrounded with persecutors'. She wrote: 'I, myself, in the role of the child had constantly to spy upon and torment the others.' Often the child played the part of the child. Then the game generally ended with her escaping from the persecutions (on these occasions the child was good). Mrs Klein then finishes her description of the fantasy game: 'After her sadism had spent itself in these

fantasies apparently unchecked by any inhibition, reaction would set in in the form of deep depression, anxiety, and bodily exhaustion. In this child's fantasies all the roles engaged could be fitted into one formula, that of two principal parts—the persecuting superego and the id or ego, as the case might be, threatened, but by no means less cruel.'

But a few pages later Melanie Klein states of another child that the 'characters in his doll play embodied the id and the super-ego'. A boy, Gerald, for whom Melanie Klein represented a fairy-mamma, who brought him the father's penis, repeatedly made her act the part of a boy who crept by night into the cage of a mother lioness, attacked her, stole her cubs and killed and ate them. Then the boy was the lioness who discovered her and killed her in the cruellest manner. The roles alternated in accordance with the analytic situation and the amount of latent anxiety. At a later period the boy himself enacted the part of the miscreant who penetrated into the lion's cage, and he made Melanie Klein into the cruel lioness. But in this case the lions were soon replaced by a helpful fairy-mamma, whose part Melanie Klein also had to play. 'At this time the boy was able to represent the id himself.' What is happening in Melanie Klein's work is a process of contamination. That delusion of persecution is a symptom of paranoia does not mean that any manifestation of spying or torture is always paranoia. In the same way, because Freud presented the concept of ego, id, and superego as a working hypothesis to an easier understanding of mental functioning, the personification of these structures as a basis for a theory is highly unscientific.

In her later works, we find more and more frequent use of the term 'persecutory anxiety', which, in the 1930s, becomes for her a manifestation of mental development in earliest infancy. There is the statement in her paper, 'The Psychotherapy of the Psychoses' (1930):

'The fact is that at this phase [the earliest phase of human relationship] external reality is peopled in the child's imagination with objects who are expected to treat the child in precisely the same sadistic way as the child is impelled to treat the objects. This relationship is really the very young child's primitive reality.'

'In the earliest reality of the child it is no exaggeration to say that the world is a breast and a belly which is filled with dangerous

objects, dangerous because of the child's own impulse to attack them. Whilst the normal course of development for the ego is gradually to assess external objects through a reality scale of values for the psychotic the world—and that in practice means objects—is valued at the original level; that is to say, that for the psychotic the world is still a belly peopled with dangerous objects. If, therefore, I were asked to give in a few words a valid generalization for the psychoses, I would say that the main groupings correspond to defences, against the main developmental phases of sadism.'

And at the end of the article she writes:

'In my opinion fully developed schizophrenia is more common—and especially the occurrence of schizophrenic traits is a far more general phenomenon—in childhood than is usually supposed. I have come to the conclusion that the concept of schizophrenia in particular and of psychosis in general as occurring in childhood must be extended, and I think that one of the chief tasks of the children's analyst is to discover and cure psychoses in children.' [Italics mine.]

Melanie Klein develops the theory that for all children in the beginning external reality is mainly a mirror of the child's own instinctual life. This she allegedly found in the analysis of children from 2½ to 5.

Observations on infants, however, reveal states of peace, contentment, and sleep, and states of great displeasure. The first six months are described by Anna Freud as the period of need satisfaction, during which to the infant the gratification of needs is more important than the person who gives this care. This period roughly overlaps with the period which Melanie Klein regards as the stage of persecution and paranoid position. To her this is the period of persecutory anxiety; even the process of birth is felt as an attack by hostile forces in which the struggle between life and death instincts also enters; the breast is split into a good and a bad one; intensive processes of introjection, projection, and re-introjection of what was projected take place. In this stage, according to her, the fantasies of the infant encompass the primal scene, and the Oedipus complex, while a sadistic superego—the introjected parental figures—operates in full force. The love object as she sees it is a 'part-object' since the infant only

perceives the breast, a part of the body, and is annihilated by the superego.

The next period of development, according to Mrs Klein, is the depressive position, when the ego of the child has to breach the gap between his internal frightening fantasies of the annihilated love object and the growing awareness that his love object is real. He has started to relate to his mother as a whole-object and not any more as a part-object. The whole good mother has to be incorporated. The first attempt to reconcile his violent and destructive inner world with the reality of a loving mother is through the hypomanic defence of denial; the denial of the depression over the destroyed love object. According to her, intensive processes of reparation and restoration now lead to reconciliation of the inner world of destroyed love objects with the more reality-adapted, introjected good whole love objects. She likens the process of restoration to a process of maturation which takes many years. Since analysis furthers this process, Kleinian analysts recommend child analysis as a prophylaxis.

It seems that Melanie Klein has accurately appraised certain mechanisms in psychotic patients whose object relationships are disturbed. She sees these phenomena entirely as a regression to genetically earliest phases. This in turn led her to her concept that all early development must be described in terms of psychotic states. It is here that the fundamental disagreement between her school of thought and other analysts results. In our opinion she disregards the fact that many of the phenomena observable in psychotic patients are not due to regressions to earliest childhood but preserve features of later stages of development.

In the *Narrative of a Child Analysis* she analyses the Oedipus complex but views this in terms of persecutory anxiety and hypomanic defences, since, according to her, the Oedipus complex operates in earliest development. The therapeutic efforts are directed towards overcoming the persecutory anxieties and support the child to arrive at an inner concept that he has not killed his persecutors—the introjected representatives of the previously projected bad love objects—but that he has repaired and restored them inside himself and made them whole.

The Analysis

Part of this child analysis has already been published as a paper, 'The Oedipus Complex

in the Light of Early Anxieties' (*Int. J. Psycho-Anal.*, 26, 1945) and it was also published in *Contributions to Psycho-Analysis 1921-1945*. It is a pity that more reports on the analysis of children are not published in this way. The usual method, an overall case report or description of fragments of the analysis, does not give the reader an account of the analytic process in microscopic form as this one does.

The analysis was of four months' duration and consisted of ninety-three sessions. Mrs Klein made her notes after each session, instead of using a recording machine. Most analysts will agree that her way of recording, although not verbatim, has more validity for psycho-analytic case presentations. Of course there are slight changes in factual content and some distortions due to normal memory fluctuations. However, this filtering through of the material, owing to time lag and unavoidable human error, does not detract from the presentation but actually enlivens it. Since analysis is a joint venture between patient and analyst, the non-verbatim case report brings the work of the analyst closer into focus.

Mrs Klein, like Freud, also notes in her preface that taking notes during the session interferes with the analytic work. Freud's 'free hovering attention of the analyst' can hardly be achieved while writing. In child analysis this is particularly true, since the participation of the analyst is needed completely and totally at all times. Moreover, the commentaries on each session, as given by Melanie Klein in this book, help one to grasp her way of thinking.

Richard, a boy of ten, had suffered from a school phobia since the age of five. The symptoms had increased in severity over the years and especially since the outbreak of World War II. From the analysis it became clear that Richard's school phobia was actually a fear of children. He was hypochondriacal and depressed. His mother was always worried about his health and was herself a depressed person. She seemed to prefer her other, older son, who was a more successful boy. The father was kind to Richard but left his care predominantly to the mother. He had been breast-fed for only a few weeks and had been a delicate child since. He had had a circumcision and a tonsillectomy between ages 3 and 6. He was gifted in language and words. He preferred the company of adults, especially women. Unfortunately, the anamnesis as presented leaves the reader with many questions, especially as to diagnosis: could Richard be

considered a neurotic child, or does he belong to the group of so-called 'borderlines'?

At the outbreak of the War, the family had left London, as had Mrs Klein. Richard and his mother stayed in the same village as Mrs Klein during the week and went to their war-time home in a nearby town at week-ends. The older brother, Paul, had been sent away with his school.

Mrs Klein describes some of the disadvantages of her makeshift war-time office, which resulted in some changes in the actual treatment set-up. The playroom contained some personal objects of the former owner, and Richard would often wait for her outside before the sessions and help her lock up and accompany her after the session. This lessened some of his anxiety, since he was afraid of children. Circumstances such as these, which do not quite fit into the analytic situation, are more easily tolerated by a child than an adult, in analysis, and can be used as analytic material. Throughout the four months Mrs Klein treated the boy by her regular child-analytic method, and she abstained from any psychotherapeutic interventions.

The merit of her work with the boy is that real communication existed between her and Richard. He felt at all times that he could verbalize his feelings, memories, and anxieties to her, and was also very open in his disagreements as well as agreements with her. It is true that this might almost be considered part of his symptomatology. In contrast to this behaviour of Richard's, the general experience with a 10-year-old is that conscious and preconscious fantasies, one avenue to the understanding of unconscious fantasies, are not easily available and a great amount of analysing of the defences is necessary.

In this short period Richard discussed his experiences with the circumcision as well as the tonsillectomy and a tooth extraction at age 7. He recounted how he had been deceived by the doctor and expressed his helpless rage and fear of him. He could discuss in his earliest sessions his feeling of rivalry with his brother Paul, and in the twentieth session was able spontaneously to bring up his sex play with his dog. His positive feelings for Mrs Klein as manifestations of his positive oedipal fantasies were clearly expressed and interpreted by Mrs Klein. He also worked out in the transference his rivalry with her fantasied husband, Mr Klein, and Mrs Klein's other patients, especially one adolescent boy.

Richard seemed an ideal patient, since he

always brought in to the sessions experiences of his daily life, his concern about whatever preoccupied him, and many memories. There is no doubt that such communications are only possible if and when a real rapport exists between analyst and patient. Such a flow can only continue when interpretations and clarifications help to open the avenues from the preconscious to the conscious.

Reading day-by-day sessions is like observing analytic work such as is presented in seminars or in supervisory sessions. One can treat the material presented as if it were one's own patient. Reading this case study, I responded in many instances with a feeling of knowing exactly what was happening in the sessions and was in full agreement with Mrs Klein; but in many other instances I could not follow and would have proceeded very differently.

What interests me is the fact that Richard frequently did not agree with Mrs Klein. When she, in the first session, told him that the tramp whom he feared might kidnap his mother was actually his father, and that Hitler was also the feared father, the boy had looked puzzled and answered that he did not think that Daddy would do anything to Mummy. Mrs Klein interpreted to him that his idea that the tramp would hurt his mother stood for parental intercourse. She explained in her footnote that this is a splitting process; he splits the good father from the bad father. While all analysts would agree that the boy's fear of the tramp was based on his ambivalence towards his father, this material does not seem available to the boy's preconsciousness at this point of the analysis.

Melanie Klein assumed that he associated her as a victim of the Nazis but overlooked that she was also identified as a Nazi, as the boy revealed after asking whether she was an Austrian: 'But wasn't Hitler an Austrian, too?'

Some of her interpretations must have struck a responsive chord—e.g. when she said that the bad Daddy ill-treated Mummy. The boy explained somewhat later that indeed there were some quarrels between the parents, especially about him.

A verbalization of this kind serves the analytic work as an introduction to the understanding of his ambivalence. This child, who talked easily to adult women, now had a woman who was willing to listen to all he had to say and by her attitude and verbalizations conveyed that she was not afraid of talking about things that most adults do not consider right or proper.

Although the interpretation of the primal scene seems premature, Richard in the next session brought more material which seemed to confirm this interpretation. He started the second session by telling that he always feared a collision between the sun and the earth, and the sun might burn up the earth and the earth was so precious with all living things on it. Mrs Klein did interpret that this collision stood for something happening between the parents, but then dealt with the people on earth, which she interpreted as the children who would be crushed in parental intercourse. When Mrs Klein reminded him of the tramp, all Richard was willing to admit, however, was that he would fight the tramp. He agreed that the earth stood for Mummy, since he knew the term Mother Earth. Mrs Klein next brought up that he also envied his parents for their enjoyment together, that this made him feel lonely and deserted, but also very angry. And because of the anger towards his parents, he felt guilty. Richard denied this, but finally admitted that he did feel frightened and unhappy when he was sent to bed at night. And he admitted that he could argue with his parents until they were exhausted and that he enjoyed this. He also admitted feeling jealous about his brother Paul, because he was mother's favourite. He then told how he hated Paul because he used to tease him and chase him. But at times they were allies against the nurse. Richard then told about a fight he had with his cousin Peter, who is much taller than himself. Mrs Klein now interpreted that Peter was a mixture of the nice father and of the bad Hitler—or tramp—or bad father, and added that it was easy to hate Hitler but painful to hate his Daddy whom he also loved.

Again in this session one finds verbalizations, clarifications, and interpretations which further the analysis, but also several interpretations which would seem premature to Freudian analysts. Interestingly enough, Richard did not respond to them. He would accept what he saw and ignored the rest. Of course in analysis of adults as well as children agreements as well as disagreements with the analyst may be a form of resistance. But in many instances Richard objected to what seemed premature interpretations.

He was able to discuss his envy, fear, and love for his brother and confessed that he was difficult with his parents at times. He responded neither to the interpretations of the primal scene nor to the one that Hitler and his father were the same

to him (two aspects of his ambivalent feelings for his father). Mrs Klein had interpreted this to him in the second session, before the defence against accepting hostility and fear of his father had been lifted. Richard had also brought in these two sessions a story of how his mother had been hurt in an accident when he was two years old. Actually this had happened before his birth. Mrs Klein likened the incident to the primal scene and interpreted that he had incorrectly dated the accident in his lifetime because he felt guilty about wanting to destroy his parents in intercourse. This may be true in the child's unconscious, but there is as yet no conscious statement of the child to verify either the primal scene or the guilt. Also we know that in the unconscious many fantasies are overdetermined. Thus, the specific fantasy operating at a certain point in the analysis can only be ascertained through careful analysis of the conscious affects and defences.

Freud in his paper on 'The Unconscious' stated cogently that a fantasy can exist in consciousness and in the unconscious and be unconnected. It is the analysis of the defences, and the lifting of the repression, which re-establishes the connexion between conscious and unconscious. Melanie Klein, in my opinion, herself introduces fantasies into the boy's conscious mind; whether or not they belong to the boy's inventory of unconscious fantasies, one does not know. She effects the lifting of the repression by the regular analytic means: clarifications, verbalization, analysis of the transference. To assess the effect of all interpretations, timely as well as untimely, requires intensive and systematic research, such as has not so far been undertaken. Non-Kleinian analysts might have discussed his mother's accident as an example of those occasions when one is helpless against superior force, just as the small European countries were helpless against the German armies. The discussion of the helplessness might have led ultimately to a discussion of his passivity, which was closely connected with his phobia (as her later material revealed when he recounted the homosexual episodes).

Melanie Klein goes on to explain in her commentary that the interpretation of internal objects is a very careful one and should only be given at the right moment. This occurred, according to her, in the fifth session, when Richard had a cold and was concerned about it. One might have discussed colds with him and

his feelings about them and whatever memories he had concerning them. One might have noted whether he took too much pleasure in talking about his health; or whether the emphasis was on fear of illness, or the pleasure in being taken care of, etc.

One realizes more and more that Mrs Klein does not use factual information as a starting-point for further verbalization and clarification. In child analysis, as in adult analysis, we feel that insight can only come from the patient's own verbalization which will ultimately enlarge his knowledge about his motivations, by overcoming resistance against preconscious and unconscious content. But Melanie Klein tends rather to use the child's communications for immediate, and I consider random, translation.

Thus she interpreted the cold as 'something bad inside him'. At this point the boy looked at a map of Europe, turned it upside down and commented on the funny shape of Europe and added he felt muddled and mixed up. This to Mrs Klein was a confirmation of the correctness of her interpretation. The boy then asked, 'How long could Sweden remain neutral?' This was interpreted as the mixed-upness of sexual intercourse when the father's penis stays inside the mother. One might wonder whether this was not a transference reaction of the child, meaning how long can a helpless person keep from being invaded and overpowered by a stronger one? This could have been regarded as a real transference reaction and would have led to the gradual analysis and understanding of the transference, in which Mrs Klein is seen as a strong person who will overpower the patient. But does the child not also reveal his question as to how long he can ward off her strange sexual talk?

Mrs Klein goes on to describe how the boy showed anxiety and looked around the room. This was interpreted as a wish to look into Mrs Klein's body, to find out whether there was a penis inside her. The boy finally noticed a picture of a robin and remarked that he wanted to be one. This was interpreted that the robin stood for a good penis or a baby and that Richard wanted to make babies with his mother and Mrs Klein. In the next session this was changed to the interpretation that the robin was the penis with which he wanted to make babies.

The boy now became more phobic and had to be brought all the way to the sessions by his mother. Mrs Klein's interpretation was that the boy was frightened of his wish to put his penis

in her and hence afraid of his 'tramp' father, and consequently felt the treatment situation as dangerous. This last part of her interpretation dealt with his real relationship to the analyst, and although it might have been made earlier, it seemed correct, and we may suppose that it furthered the analysis. We might have expected the boy to show more resistance to coming. His need for a close relationship with an adult must have counteracted this resistance. Also, he knew from the beginning that the treatment would last only four months, and he was desperate because plans for going to school had to be made.

The boy then spoke about lonely Rumania and the disruption of life in many countries. This was translated to the boy as his desire to have his mother to himself, but also his fear that he would then have father and brother against him; and Mrs Klein explained that this was the reason for his fear of other children. The content of this interpretation probably has truth in it; only the material as presented by the boy does not warrant this interpretation at this point of the analysis.

Moreover, the material of the case which Melanie Klein presents does not warrant her interpretations. However, many fantasies had been available to the boy at one time or another in his life, and one can assume that she struck a responsive chord and awakened some of these fantasies—for example, a boy of ten has some factual knowledge about a penis going into a woman. Some positive reaction to her interpretations was therefore to be expected, but this in no way proves that all interpretations were correct at the time they were made.

The boy then told how he had lost a trowel in the sand and he considered it a major tragedy. This was interpreted as his fear of losing his penis; but now the analyst referred to what she heard from the mother about his operation for circumcision. The boy entered the discussion about this and brought many memories; how he had been lied to; they had told him he would be asked to smell perfume and he had brought a bottle of perfume along to the hospital. When he was not allowed to smell this before the anaesthesia was given, he had wanted to throw the bottle at the doctor and fight him. He had hated the doctor ever since. When the ether was given, he said that it felt 'as if hundreds or thousands of people were there'. This was translated to him to mean a feeling of persecution. The nurse, whom he felt as kind and a

protector, was explained to him to be the good mother; but his mother was the bad mother, since she had lied to him. Richard responded to this with a discussion of two robins. Actually his changing the topic to the robins should have been observed and analysed with him. Was this a response to the good and bad mother? Or was the whole discussion too upsetting? Was he wondering whether Mrs Klein would operate or send him to a doctor? Or did he not like to hear that his mother was a bad mother to him? But instead Mrs Klein told him that the robin stood for an erect and injured penis. He then pointed to a picture of two dogs, with a puppy between them. This was taken up by Mrs Klein to mean his wish to separate the parents in bed together; also that he had a fear of their uniting against him, or that they were quarrelling; that he might feel that he was the cause of their quarrel.

This last addition is again the kind of interpretation which the boy could understand and verbalize as one of his concerns.

In this sixth session the transference interpretation that the analyst represented a frightening figure because she brought out frightening thoughts and the discussion of the operations again, especially the circumcision, must have had a real therapeutic effect. And, as was to be expected, the boy was in a better mood when he left. But he twisted his foot coming to the analysis the next day and reported that his canaries were ill. They were getting bald. This was interpreted that he had made his Daddy ill, had injured his genital as well as his head because he wanted to take the father's place. (This was not true in reality; the boy had only reported that he had playfully hit his father on the forehead with an arrow.) This was then linked up to his fear of the doctor who had operated on him.

A discussion of his wild and aggressive behaviour to his father was definitely in order, and also its relation to the circumcision. And a full discussion of the self-injury might have been considered timely as an introduction to discussing his fear of castration.

The boy again looked at the map. His father had made a joke about Brest, the French town, and said the Germans were going to attack the legs now they had started with the breast. Then the boy remarked on the room—that he did not like it, a picture was brown; also he turned Mrs Klein's clock round.

It seems to me that the discussion of the opera-

tion had mobilized the boy's aggression; his need to take revenge on the doctor who definitely was a father substitute. But instead the analyst took up the reference to anality because of the colour brown and remarked that his worry that the Germans would soon attack England revealed a fear that his father would attack his mother, although the material clearly showed that the boy was dealing with a fear that his father would attack him. Here the interpretation did not at all catch the child's mood of wanting to fight and to be excited. His interest shifted to a painting with a mountain, which was symbolically interpreted as his wish to keep the mother's breast undamaged; again probably correct, but not at the time available to consciousness.

When in the next session Mrs Klein met him on the road because she had forgotten the key, she interpreted how frightened he was about losing time and not always finding the room open. He then told some dreams and while telling them played with fire. This was interpreted as his mother's body, which contained the bad Hitler father, and he wanted to destroy him by burning. That same hour the boy went to urinate, but this was not discussed by her, not even symbolically. The dream was not associated to, only interpreted symbolically.

Mrs Klein interpreted his rejection of her offer to make up lost time because he wanted a different hour as agreed, and his fear of it. In her commentary she states that here was a conflict between impulses to attack and to keep alive a loved person; they stem from anxieties in the baby in relation to its mother and her breast as an external and internalized object and the urge to destroy the bad object inside the good one; partly for the sake of the object, partly for the sake of the subject. According to her theory, these fantasies develop when the love object is perceived as a whole person, not any more as a part object—the first and earlier phase of development as she conceives of it. The interpretation of these anxieties, according to Mrs Klein, diminishes the depression and the manic defence which she sees as a step in the ego's greater capacity to deal with depression. Such steps are inherent in normal development when the infant goes through the 'depressive position'. Analysis furthers this process. The boy's answer to the interpretation of the greed is that he is a rat. He wants to burrow his mind into hers, he wants to know all her secrets.

This is a session where from the material it is

obvious that the positive sexual transference is coming to consciousness; the boy caresses her clock, wants to know about her. Then the boy admired a picture of a battleship and associated with it a captain whom he admired. Suddenly he bit the edge of the picture and bit his own cap.

The interpretation was given that the cap stood for Daddy taking care of Mummy, the battleship he did not want to think of was the dangerous rat—father—because thinking of a good father comforted him when he was afraid of the rat-father (manic defence), explains Mrs Klein. She also suggested that when he admired Daddy's strong and potent genital this meant that Richard had not injured it; also that the strong father can protect the mother; but that Richard felt jealous and envious of this potent genital and wanted to bite it off.

The boy was now very affectionate to Mrs Klein and called her sweet.

This session brings out the striking difference in Melanie Klein's technique. In a classical child analysis the material which indicates the positive transference would be considered the most important. It leads to the interpretations dealing with the positive Oedipus fantasy. The biting could have been discussed in connexion with his excitement. At a later date in the analysis this could then have been linked up with the fantasy that in sexual intercourse one partner bites the other. The oral elements were present in a later dream which Richard related and associated to. Such fantasies stem from an oral fixation which explains the oral element of the fantasies in the phallic phase.

Melanie Klein is less concerned with the oedipal fantasy as such. In her theoretical concepts these fantasies are subordinate to the struggle of the ego to overcome the depression; in the second phase the ego has to restore the love object which was destroyed by the superego in the paranoid phase. Hence she searches in the material for destructive fantasies as well as for indications of the process of reparation. At some points her interpretations and discussion coincide to some extent with those a non-Kleinian analyst would have made: for example, in the discussion of the boy's attempt to control his hostile impulses. But from that point we would again have pursued a different course.

During the analysis Richard made a series of seventy-four drawings, which were interpreted in Mrs Klein's way; e.g. using the child's explanations and interpreting these and her

impression of what it all meant to the boy symbolically. As is understandable in a boy of 10 during the War, many drawings dealt with submarines and sea battles. The carefully drawn waterline was interpreted as the dividing line between the conscious and unconscious mind. The fish stood for penises or for children; the submarines and battleships for various members of the family.

The boy also told seven dreams. He gave associations to some when Mrs Klein asked for them. It is not clear why she asked associations at some times and not at others. The dreams were also interpreted in the usual Kleinian way. Again one finds a mixture of well-timed and unconvincing symbolic interpretations.

In the second dream he was invited by fishes to have dinner with them, but he refused, as this would lead to great dangers, but he said he did not care and would go to Munich instead; he met his parents. Also in the dream a train went off the rails; there was a fire which chased Richard; he fled, deserted his parents; he fetched buckets of water to put the fire out; he helped the ground to become fertile.

Mrs Klein this time asked him for many associations, in contrast to the first dream which had only been interpreted symbolically. Richard replied that he refused the dinner invitation because there would be fried octopus which he hates. He did not know why he went to Munich. Mrs Klein interpreted this that he regarded Munich as a very dangerous place, to which he agreed. She then continued that he was afraid of the internal danger, that he would devour all Mummy's children, and the fried octopus stood for Richard's father. Going to Munich in the dream stood for an external danger, while the fried octopus and the leader of the fishes stood for the bad Hitler-father—Mr Klein in the earlier material. This she regarded as a flight to external danger, as a defence against internal danger. To which Richard agreed with conviction that it would be much easier to fight Hitler in Munich than in his inside.

The boy had started the session with curiosity about another patient, and had asked Mrs Klein if she would talk about him. He had also asked whether she would talk to her husband about him, although the boy knew that Mr Klein was no longer living. This was now interpreted that he concerned himself about Mr Klein inside of Mrs Klein. The fire of the engines which was pursuing him was felt to be inside him. His hope was to save his parents with good fertilizing

water (in the previous hour it had been interpreted to him that he had eaten his parents in sexual intercourse). This water was his good urine, while the bad fiery stuff coming out of Daddy's engine was felt to be dangerous urine which would burn Mummy and him.

Richard had listened listlessly and played with his toy fleet. Then he blew up a football, lay on it and squeezed the air out, saying this was Mummy who was empty and crying. He then fetched a broom and swept the room clean. Mrs Klein now interpreted that he was improving his internal Mummy.

She next asked him what he had for dinner, and he looked surprised and interested and said: 'But then I dreamed that the fishes had asked me to dinner.' He left in a serious mood but not unhappy.

Since for several sessions Mrs Klein had talked to him about fishes who stand for babies and who eat the mother, it seems quite possible that Richard's oral fantasies received a great deal of stimulation.

But it is very difficult to determine what in the material he brings is ready to be understood and worked through from a non-Kleinian point of view. It seems quite possible that the talking of eating and devouring aroused a fear of being eaten. His last statement that the fishes invited him to dinner may well be understood in this way.

The analysis continued to be the same mixture of facts of everyday life, true memories from his past, and playing and drawing. This is the most desirable way to conduct a child analysis. One gains the impression, however, that information about the boy's daily life and memories was not utilized to the fullest extent; not even when the boy reported the serious illness of his father, or confessed that he had had a bowel movement in his pants. All this was subordinated to interpretations of completely symbolic nature which dealt with the vigorous processes of destruction and reparation as postulated by Melanie Klein, but which to this reviewer are not proved from her material.

From the first moment in the analysis Melanie Klein interpreted unconscious fantasies from all phases of infantile development. Many of these fantasies must have existed at some time or other in the boy's mind, as for instance the fantasy about the small, helpless European countries (page 502). Never did Melanie Klein analyse these

fantasies genetically, only dynamically and in a random fashion. Most of the time there was no way of knowing the exact meaning of the symbols. Why was a robin or a fish called a penis or a baby? When did Melanie Klein know from the material what was inside or outside? Why was the colour red in a drawing blood and bad, or the colour blue a representative of the good mother? Moreover, material which seemed to confirm her interpretations was not convincingly put together. And most important of all, at no point in the analysis was it possible to establish from the material to what age these fantasies belonged and to which phase of the child's development they could be referred.

The analysis ended when Melanie Klein left to go back to London. The boy pleaded to go with her to continue his work with her. His sadness over her leaving was clearly expressed. He also knew that he would have to go to school. Melanie Klein implied that she would intercede with his mother on his behalf to choose a small school.

The boy seemed to have improved, but unfortunately there was no follow-up study. All workers in the field know, however, that one cannot expect too great and lasting results from four months of analysis.

But there is no doubt that the boy seemed to have gained a great deal. During these four months he had had a chance to analyse partially his positive Oedipus complex and his castration fear; he had brought up some homosexual fears and episodes, and had discussed ambivalent feelings; he had also brought up his fear of being poisoned. And Melanie Klein mentions that Richard learned to go out by himself on his bicycle and was willing to accept going to school.

This analytic case report leaves the non-Kleinian analyst with a feeling of some bewilderment. Both the analytic technique and the treatment goal seem so fundamentally different from what we know. Although the same interpretations are sometimes given, the timing is frequently reversed. In classical analysis, the analysis of the defences is a most consistent one and is only undertaken after careful evaluation as to which defence to analyse (see Frankl and Hellman²). In Kleinian analysis, analysis of the defences is limited to the mechanisms of projection, introjection, so-called manic defence and denial, and these, moreover, are analysed in

a non-systematic way. One does not find a correlation between specific id fantasies and the particular defences that ward them off. Nowhere is there an indication that the analysis of the material proceeded in such a way as to lead to genetic interpretations. The id interpretations in a non-Kleinian analysis are arrived at very slowly and with great precision, whereas in a Kleinian analysis they are non-systematic and repetitive, and stem from all levels of psycho-sexual development indiscriminately.

Whether we read the first or any other session of this case report, they all strike us as similar in level of interpretation. There is nothing that gives an awareness of unfolding or development of the analytic process. Never was the conviction conveyed that we are dealing with conflict between opposing forces; drive derivatives as opposed to defences; past as opposed to present; fantasy as opposed to reality. Moreover, from the case material and from this type of analysis it is impossible to infer any theory concerning early childhood development. Klein's random way of interpreting does not reflect the material but, rather, her preconceived theoretical assumptions regarding childhood development.

Her treatment goal—that of restoring the

'destroyed internal love object' and reconciling this with the incorporated image of the real, external, love object—is not one of the goals of a non-Kleinian. But if her formulation is another way of saying that the treatment goal is to improve reality testing and to overcome pregenital fixations and relations to objects so that the ego can relate adequately to actual love objects and be free for sublimation, then Kleinian and non-Kleinian analysts are in agreement. But for a non-Kleinian, most of Melanie Klein's technique cannot be considered child analysis, although some of it is, and all her work is skilful and humane.

Whether one is a Kleinian or not, all analysts owe Melanie Klein much respect and gratitude. Long before many workers in the field had become aware of it, she stressed the all-importance of the first year of life for the development of the human being. But in spite of the importance of her work, classical analysts regret that they cannot agree with her theories concerning the first year of life.

This *Narrative of a Child Analysis* is an important document for all those who are interested in understanding the controversy between the Kleinian school and classical psycho-analysis.

'NARRATIVE OF A CHILD ANALYSIS'

2. By

HANNA SEGAL and DONALD MELTZER, LONDON

Introduction

Narrative of a Child Analysis, which appeared posthumously and is the last book written by Melanie Klein, was planned by her as a companion volume to *The Psycho-Analysis of Children*, published in 1932, in which she described her technique of play analysis, and gave an account of the psychological findings she obtained from this technique. As is by now well known, the pioneering technique she evolved was based on the assumption that children's play reflects the unconscious.

A book such as the *Narrative*, unusual in the literature of psycho-analysis and unique in child-analytic writings, presents a knotty task for the reviewer, since it can, and in fact must, be read in different ways by workers of different degrees of familiarity with that line of development in psycho-analysis leading from Freud and Abraham through Melanie Klein to the recent work of her students and co-workers.

For students of psycho-analysis, this volume will be primarily a companion to *The Psycho-Analysis of Children*, especially those chapters on technique with latency-period children, and on the psycho-sexual development of the boy. Although the material of the *Narrative* must be overwhelming in detail for a student, a reading of the book and seminars on particularly clear and moving sessions such as the 6th or the 24th would probably be the best introduction to the development of play technique by Melanie Klein and the discoveries which analysis of young children brought to light.

Analysts particularly interested in Mrs Klein's work, but not acquainted personally with her during her lifetime, will be deeply interested in the *Narrative* for the vivid picture it gives of her as a person and as an analyst in action. Close study should be rewarding, if careful attention is paid to notes and footnotes, ample use made of the excellent index, and other papers referred to. But even then this volume may present difficulties for reasons we will discuss later.

Since Richard was both a highly verbal child and also brought dreams, this volume can be read with profit by those whose experience is only with adult patients. To analysts for whom the Kleinian developments in psycho-analysis are a central concern, this volume comes as a gift and as a responsibility. Reading it with understanding and gratitude to the author is only the beginning of the responsibility it entails.

For younger analysts and those to whom the controversies of the thirties and forties concerning technique of child-analysis, the transference reactions of children, the pregenital oedipal conflicts, etc. are only history, this volume must come as a surprise. The name of Melanie Klein is likely to be associated more intensely in their minds with the recent controversies about the paranoid-schizoid and depressive positions in object relations, the role of envy, the significance of projective identification, and the nature of the therapeutic process. Thus they may find to their surprise that the name of Melanie Klein should be associated with so much that has become accepted—or classical, if you will, and not only with controversial problems. In this volume they will see at work the technique that enabled Melanie Klein to make those early discoveries which are now so widely accepted, while at the same time they can observe in an unformed state the theories which are now so controversial. In none of her early writings is her emphasis on internal object relations (the details of unconscious superego relations) so richly documented as in the *Narrative*.

The Structure of the Book

Unlike other workers in the field at that time, Melanie Klein assumed from the start that children were analysable and confined herself strictly to the analytical work, to the exclusion of any educational, critical, or reassuring intervention. She maintained towards the child the analytical attitude, and provided an analytical setting: she was able to confirm her expectation

that children develop a transference and the transference neurosis. Her work has given rise to a wide controversy about the validity of both her findings and her technique, and many misconceptions have arisen as to what actually happens in a 'Kleinian analysis'. In 1932, in *The Psycho-Analysis of Children*, she was concerned with describing her technique and formulating some of her discoveries about early anxiety situations, and, in particular, the early stages of the Oedipus complex and the formation of the superego. She was less concerned with the presentation of actual clinical material. *Narrative of a Child Analysis* provides a detailed account of the course of a child psycho-analytic treatment, the factual description of the happenings in the playroom. From that point of view alone, the book is invaluable as a source of information and could be used as the basis of fruitful discussion. The analysis described took place in 1941, at a time when Melanie Klein had not yet drawn the full implications of the differentiation of the paranoid-schizoid and depressive positions, nor had she yet described the schizoid mechanisms. The working of these mechanisms, particularly splitting and projective identification, is often clearly seen during the analysis, and as we follow the patient's material, the way Melanie Klein interprets these mechanisms and the phantasies underlying them gives some evidence of the kind of experience on which she based her theoretical conclusions, and some insight into her creative thinking.

The book gives a day-to-day account of ninety-three sessions with Richard, aged ten. The child's play and associations, and their interplay with the analyst's interpretations, are described as accurately as could be done from notes taken immediately after the session. The majority of the child's drawings are reproduced. The accounts of most of the sessions are followed by chapter notes of great interest, which show the analyst's mind at work. Sometimes they are theoretical discussions of the sessions; sometimes they contain explanations as to why certain interpretations were given, or how they affected the patient. On other occasions, the material is formulated in the light of her later theories. Some of the notes point out the mistakes that have been made and their effects. For instance, in the sixty-fifth session Richard insisted on Mrs Klein's telling him whether she threw out or salvaged certain pieces of paper. (To Richard, salvage was a most patriotic activity.) She eventually answered that she had salvaged

the pieces of paper. In her chapter notes, Mrs Klein points out the effect of this reassurance:

'This is illustrated by the remark which immediately followed on Richard's having stated with pleasure that I was patriotic—that is to say, a very good object—and which indicated that I had at that moment increased the positive transference. His very next remark referred to the girl on the road who, although of quite harmless appearance, looked to him like the monster. That is to say, idealization of the analyst—the patriotic and not foreign and suspect Mrs K—had not resolved the doubt in her; but this doubt was deflected and transferred to the girl passing by. The only way to diminish such suspicions would have been to interpret them.'

The structure of the book is completed by a detailed index which will help the reader to trace crucial items of play, to cull out dreams, to refer backwards and forwards with ease.

This structure, text of sessions, drawings, footnotes, chapter notes, and index, even when taken as a companion to the 1932 volume and an introduction to later work, must disappoint individual requirements. The student would wish for summaries of the flow of the analytic process, say from week to week. It might be felt that a more emphatic documentation of controversial theories would be in order, and some comparison with formulations by non-Kleinian workers. It would certainly be fascinating had Mrs Klein spent some time clarifying her way of choosing among the alternative formulations often suggested by the material. Some attempt at a retrospective evaluation of the theories and technique in the light of her subsequent experience would have enriched the reading for analysts well acquainted with her more recent findings. Remembering Melanie Klein's age at the time of preparation of the book, and remembering its size, one can realize that these disappointments are a measure of the richness of the interest stirred by the volume as it stands.

The Analytic Problem

Richard, from the age of 4 or 5, had been suffering from a progressive inhibition of his faculties and interests by hypochondriacal anxieties and depression. He was inhibited and frightened of other children so that, at the age of 8, he had to stop attending school, and gradually his fears increased so much that he was hardly able to go out by himself. The outbreak of war

increased his anxieties, and he was referred for treatment at the age of 10. Mrs Klein undertook his analysis with some misgivings, since it was known at the start that, because of external circumstances, it could only last four months. She felt, however, that in spite of the time limitation the child could be helped, and that the most effective way of helping him would be to analyse him, keeping in all essentials to her usual technique.

Quite desperate for help, Richard, from the very first session, strove hard to reveal his conflicts and anxieties. His attempts to deal in the analysis with his aggressive feelings aroused in the oedipal situation by projecting them into his father led to the splitting of his father into a good figure and a very bad one, the bad one predominating in the early stages of the analysis. His mother was also split into an ideal 'blue mummy' and a mother possessed by a bad father, seen sometimes as destroyed and sometimes as allied with him against Richard. The brother was equally split, sometimes appearing as Richard's ally, sometimes as the enemy.

Richard made it clear in his play, his drawings, his verbal communications that for him the world was composed of these figures, and that their mutual relationships, as seen or phantasied by him, preoccupied him constantly and filled him with anxiety. The bad father might attack and annihilate mother and Richard; the bad father and the mother containing him ('the wicked-brute mother') might attack Richard; father and brother might combine to rob Richard of his mother and her breast and milk, which he felt he needed for survival; the mother's unborn children were felt as a constant threat to himself and his mother. Other people in the child's environment and external events such as the war were felt and interpreted by him in terms of his own inner anxieties.

Perhaps discretion, but most likely the desire to keep the interest centred on technique and theory rather than on psychopathology, have caused Mrs Klein to give relatively little information from which diagnosis, prognosis, and etiology of the boy's illness could be established. The reasons for choosing Richard's analysis to illustrate her work with children seem to have been primarily fortuitous, namely that the situation afforded her time for ample note-writing after each session. The quality of Richard's cooperation and the richness and variety of his material tend to compensate for the drawbacks of the setting, the separation from parents, the

external pressures of the war, and the short duration of the work, all of which makes comparison with other analytic processes rather difficult. Mrs Klein does try to trace the consequences of these undesirable factors.

The Analytic Process—Technique

In the first session, Richard brought to analysis material that enabled the analyst to make immediate contact with his leading unconscious anxiety situation which centred on his oedipal conflict. He started the session by confiding his fears about the war and his hatred of Hitler's cruelty in relation to conquered countries. He also spoke about his curiosity and anxiety about his own and other people's insides and the way blood flowed. He spoke about his mother's accident, when she was run over and brought home on a stretcher, his fears about her health, and the fear also that a nasty man, a kind of tramp, would come and kidnap her during the night. Behind these conscious anxieties we can already see the configuration of his Oedipus complex at that moment, the bad Hitler-tramp, father, attacking his mother at night, ill-treating her and making her bleed. This is the situation that was interpreted, including also a transference interpretation about the Austrian Mrs K, occupied by Hitler, standing respectively for the mother and the bad father. This situation was elaborated further in the next session, probably because the interpretation lessened the anxiety and rendered it more conscious. Richard was able to admit his jealousy and hatred of his brother, standing for his father; and, once this jealousy was admitted, love for his brother and father could be mobilized and expressed. In this session, Mrs Klein was able to interpret to him some of the projection of his own bad feelings into his father, which made him into a Hitler or a dangerous tramp.

Quite soon, we can observe in the material that the various figures composing the child's world were also internalized. For instance, after the fourth session, in which he confessed his biting, he developed a cold and made a slip of the tongue, saying 'He knows his blows', instead of 'He blows his nose', thus identifying his cold with internal 'blows'. In the seventh session, he showed how he could internalize the analyst, by describing how, during the weekend break, 'You were about. It was as if I had been seeing a picture of you.' But it was only in the twelfth session, after Richard had expressed clearly his wish to eat his analyst's brain, and

showed that he felt that he had devoured his parents, so that they became part of him, that Mrs Klein interpreted to him how he introjected her and his parents. From that moment onwards, what she had to follow in the material were not only Richard's phantasies about his objects, but also the way he internalized them and used them to build his internal world. In the twelfth session, Richard, for the first time, divided the upper part of one of his drawings from the lower part with a horizontal line. This dividing line later reappeared in many subsequent drawings. These lines sometimes represented the division between his conscious mind and his unconscious, but very often also the division between what was external and what was internal.

The splitting of the parental figures in the oedipal situation led to constant anxiety of a persecutory nature, and when the split figures were internalized, to a paranoid hypochondria; but it protected the child from the full experience of his oedipal wishes, the aggression associated with them, the guilt and depression. Whenever the paranoid attitude lessened and Richard was exposed to the full impact of his own destructiveness, a dramatic struggle ensued between his good and his bad feelings, in which he strove painfully to control his bad feelings. If he failed, he experienced deep depression and guilt. Throughout the ninety-three sessions we can observe the child's struggle to accept his disowned wishes and responsibility for them. The experience of his oral greed towards his mother, the murderousness towards both his parents when his jealousy and envy were aroused, led to intense feelings of guilt and loss, and he defended himself against this experience by re-splitting his figures over and over again. On other occasions, however, the recognition of psychic reality, the integration of the parental figures, brought marked relief from anxiety. Towards the end of his analysis, he was much better able to accept his ambivalence, thus increasing the security of his internal figures. His external parents were consequently experienced by him in a more realistic way. He was particularly relieved at the lessening of his paranoid attitude in relation to his father.

It is difficult for the reviewer of a book so rich in material and so detailed to decide what aspects or what parts of the book should be commented on. *The Narrative of a Child Analysis* forms a complete whole. It is indeed a true narrative, in which the story of the analysis and the history of the boy are seen as they

develop. This makes it difficult to quote any particular happening or to isolate for comment any particular session without tearing them out of their live context. But we should like to say something about the aspects of Richard's analysis which are most striking.

One is the way in which Melanie Klein makes clear to the child his unconscious phantasies about himself and his external and internal objects. The analysis goes on against the background of war, which is always present in the child's mind. External events impinge on him, increasing or lessening his anxiety in a way clearly reflected in his sessions and closely followed by the analyst. Events similar in nature affect him differently at different times. For instance, in the twenty-second session the threat of the invasion of Crete increases his anxiety about the war situation, but lessens temporarily his anxieties about his internal world, as he used the external situation as a defence against internal dangers. He agrees with conviction that 'It would be easier to fight Hitler in Munich than in his inside.' In other sessions, however, the invasion and the fall of Crete lead to a feeling of hopelessness. In the thirtieth session, for instance, caught between internal and external enemies, he feels in despair. Mrs Klein notes that he told his mother that if Britain were to lose the war, he would commit suicide.

At the same time, the anxieties about his inner world get projected into the war situation and other dangerous situations, constantly increasing his fear and exaggerating external dangers. In the thirty-fifth session, after the fall of Crete, Richard is so paralysed with fear about the war situation that he can hardly bring himself to mention it. But when Mrs Klein analyses his anxiety about his bad internal father and the projections of his aggression into him, his anxieties about the war situation lessen and he can verbalize them more freely. Similarly, when she has to interrupt his analysis to go to London for a few days, his realistic anxiety about her being exposed to bombing is increased by his omnipotent hostile phantasies that she should be destroyed by a sadistic, sexual partner. Not only present events, but past traumatic events, and the phantasies about them (e.g. operations inflicted upon him) are revived in the analysis and the phantasies analysed and gross distortions lessened. Throughout the analysis this interplay of external and internal situations is carefully

followed; and by clarifying the nature of his omnipotent phantasy the analyst enables the child to distinguish between real external objects and events and the internal phantasies projected onto them. The analysis of these phantasies, furthermore, helps him to establish his identity. Through the analysis of his projections and introjections, Mrs Klein enables Richard to distinguish himself from the objects with which he constantly identifies.

The second feature which strikes us and which is clearly illustrated in the sessions is the handling of the positive and negative transferences. Neither is ever lost sight of, and the conflicts and vicissitudes of positive and negative feelings are closely followed. As is well known, Melanie Klein, in her theoretical formulations, lays great emphasis on the role of the death instinct and aggression throughout the child's development, and her theoretical formulations may be felt as harsh. It is sometimes contended that she 'blames too much on the child'. Her interpretations to Richard of his aggressive impulses are entirely free from criticism. She sees his aggression not as something 'blame-worthy', but as a problem with which the child is faced. She never omits to interpret to him his anxieties about his aggression, his struggles with it and the pain it causes him; and though she interprets his feelings with objectivity and never draws back out of fear of causing him pain, she interprets to him with deep sympathy and handles the problem of his destructiveness with a tact and understanding that could be described as tenderness.

The student will want to pay particular attention to the opening sessions, for a great deal of the criticism, even at this late date, of Kleinian technique seems to centre on the idea that the giving of so-called 'deep' interpretations from the very start characterizes Mrs Klein's work. In the *Narrative* he will be able to see the vacuousness of this criticism based on misunderstanding. The concept utilized is simply this, which no one any longer really challenges: that the analytic situation is most securely established by the interpretation of the most pressing anxieties regardless of their developmental level. As a result of this, of relieving some of the distress and isolation involved in these anxiety situations, the positive transference is fostered, based on the child's desire for understanding and the relief it affords him.

The student will also recognize that the

establishment of communication by verbal means is part of the child-analyst's task. Melanie Klein can be seen to accomplish this in various ways, by direct questions, by asking for associations, by clarification of verbal usage, but above all through the technique of interpretation. It is surprising to see the extent to which Mrs Klein is able to reflect in the phrasing of interpretations the qualities of thoughtfulness, suspended moral judgement, and deep interest—the analytic attitude, in fact.

While the element of tact was very strong in her technique, Melanie Klein felt equally strongly that interpretations which were well founded on the presenting material should not be withheld either for fear of causing psychic pain or out of more theoretical concerns such as 'timing'. Her conviction was that an interpretation, presented in the proper analytic attitude, would not increase anxiety, but only mobilize it towards consciousness. This can be seen over and over again in the *Narrative*, the sequence: interpretation, mobilization of anxiety, increase of material, further interpretation, relief of anxiety. By searching out Richard's anxieties, by showing him his areas of conflict, by the sympathetic revelation (more implicit than explicit at the time) of his splitting processes, Mrs Klein can be seen to avoid ever confronting the child with a totally ego-alien image of himself. This was the core of the tactfulness in her technique.

Analysts who know Melanie Klein's concepts well may find themselves impatient with her at times, forgetting, as it were, that this book contains material from twenty years ago. Why does she refer so much *back* to the parents instead of drawing these feelings into the transference? Why is masturbation not mentioned until the 34th session? Why does she pay so little attention to the week-end separations and the upheaval of her trip to London?

The evidence is unmistakable that twenty years ago these elements had not as yet found their full place in her technique. Even to Melanie Klein the transference was not seen to have the unique and pervasive place in the child's life, in many ways quite separate from his life outside analysis, which she later came to recognize. The role of masturbation in launching destructive attacks against internal objects was not so fully appreciated. But what is so impressive is the method of work that Melanie Klein employed, a method of constant inquiry, never hemmed in by theoretical conceptions, always

ready to find something new, to discard an old interpretation when contrary evidence arose, to offer a new formulation. The 'wicked brute' material which begins in session 23 may be taken as an example. In the session, Mrs Klein interpreted this 'wicked brute' as the bad father whom the mother was felt to allow inside her (p. 109). Also, she suggests that when her interpretations cause Richard pain, he feels her to be the 'brute' (also p. 109). The following session (24th, a Saturday) she emphasizes the suspicions of the mother and herself in the transference as the 'wicked brutes' who invite the bad penis into them (p. 111). Later in that session, she stresses the element of alliance by Mrs Klein with Mr Klein against Richard as the 'wicked brute' mother, also represented by the football, from which he had squeezed the air in the previous session (p. 112). But on Monday (25th session), she returns to interpreting the 'wicked brute' as the bad Hitler-father's penis inside the mother or Mrs Klein (p. 117). Finally, in the 26th session (p. 120) she seems convinced by the evidence that the wicked brute is herself when she is felt to contain a son and husband who are hostile to Richard. When it is mentioned subsequently (pp. 122, 134, 153, 194, 230, etc.) it has become a piece of well-authenticated insight and can be referred back to, time and time again.

Mrs Klein took four sessions to establish the insight concerning the 'wicked brute', that it in fact referred on a part-object level to an alliance of penis and breast (see Note 1, p. 118). This method of continual sorting of confirming or refuting evidence in order to erect lasting insights around crucial bits or sequences of material, was her mode of operation. While an interpretation would be presented from conviction that it made a valid attempt to account for the material at hand, its validity would have to be judged from the patient's attitude and subsequent material. The insights, such as the 'wicked brute', she establishes by serial approximation. The alternative method, of not interpreting until enough material has been collected to document with certainty, prevented, she felt, the togetherness of full cooperation between patient and analyst. In the *Narrative*, the analysis can be seen to become a process of alliance of the most mature and healthy part of the patient's ego with the analyst in search of the hidden truth, rather than a more concrete process of gratification and frustration utilizing the 'corrective emotional experience', the

'personality of the analyst', 'meeting dependency needs', or other similar aspects of the therapeutic factors in psycho-analysis. Melanie Klein always believed that insight was the chief therapeutic agent in analysis and the main line of defence against regression after termination.

The Analytic Process—Theory

Since Richard was a child with very strong hypochondriacal trends, his material, even these brief four months of analysis, affords a rich documentation of internal object relationships. We can see here the kind of analytic material, so much more obvious and unequivocal in children than with adult patients, which contributed to Mrs Klein's early recognition of the concreteness with which the more primitive component objects of the superego are experienced in the unconscious. Richard's colds, his sore throats, his sudden abdominal pains during sessions, the drama of his taking objects into his mouth, going to toilet, squeezing the football as if it were in his tummy—all these items make the internal processes vivid to the reader, and show how concrete they were to Richard and how confused with external objects and events. But it is not entirely Richard, nor the fact of his being a child, which causes the material to flow so richly. It is the continual interpretation, the linking of current material with earlier sessions, the recalling of unanalysed bits of material, the constant working over and revaluation of data, which produces this rich flow and the many astonishing episodes of confidentiality and revelation by Richard. The intensity of Melanie Klein's work, her attention to detail and her capacity to remember and organize material is truly impressive. It lends force to the conviction of analysts, in the face of scoffers and critics, that the theories of this science have been the fruits of voyages of discovery in the depths of the mind, not of speculation.

The *Narrative* will be of very special interest to those who know Melanie Klein's work well and have closely followed the development of her researches. Analysts who took an interest in her work before the war will feel quite at home with the clinical material and find little other than emphasis to distinguish the theoretical framework of the interpretive process from classical theory, then as now. But to the post-war generation of analysts and especially to students, the scope of her post-war work is intensely brought home. One can see how

difficult it is to interpret gently without a full appreciation of the role of splitting in the self; or how confusing it is to interpret guilt and distinguish it from anxiety without the clarifying concepts of the paranoid-schizoid and depressive positions; the impossibility of comprehending claustrophobic anxieties and Richard's dread of other children without the concept of projective identification and knowledge of the unconscious phantasies of the inside of the mother's body. It all brings home forcefully the fact of how each new generation in science is indebted to the pioneers who went before. There can be very little doubt that this book, *Narrative*

of a Child Analysis, will make its contribution to the growing conviction among analysts that Melanie Klein was one of the great pioneers of psycho-analysis.

This brings us back to the responsibility which the *Narrative* brings with it for those interested in research. It will require exhaustive study and detailed analysis. It establishes a precedent, a base-line, as it were, of exposition of theory and technique in action, which will require periodic repetition. Perhaps, above all, it presents an example of integrity in scientific communication to which we must aspire.

SHORTER REVIEWS

Adolescents: Psychoanalytic Approach to Problems and Therapy. Edited by Sandor Lorand and Henry I. Schneer. (New York: Harper/Hoeber, 1961. Pp. 380. \$8.50.)

Sandor Lorand and Henry Schneer have brought together a cross-section of theory and its clinical application widely accepted among psycho-analysts today. The book, *Adolescents*, has an important part to play and no easy task to solve. One of its roles lies in facilitating access to the work of psycho-analysts and making it available to those who are concerned with adolescents in educational or therapeutic work, but for whom access to the relevant papers, published mostly in periodicals, is difficult.

The book has grown from a series of lectures given at the State University of New York and planned for residents in psychiatry, but attended also by other workers in the field. This in itself may seem remarkable to readers in countries where psycho-analytic teaching as part of a medical training programme at a University is as yet unknown.

Among the nineteen contributors the names of many who are well known for their work with adolescents are included, and it is clear that all the authors have rich clinical experience with this age group. Papers whose authors bring an original approach stand out, but in the context of a book that aims at giving a picture of most aspects of adolescence the value of papers in which the well-known basic problems are summarized and illustrated is equally important.

Although only two papers deal explicitly with therapy, the whole range of difficulties encountered in analysis with patients between puberty and adulthood unfolds throughout the chapters. Specially interesting technical considerations are to be found in Marjorie Harley's paper on cases with premature genital stimulation, as well as in Selma Fraiberg's discussion of the problem of passivity in the analysis of a boy.

The editors' aim of providing a book that can serve as a basis for teaching has been fulfilled, and the papers open up the way towards study of the many phenomena by which adolescence manifests itself. It also draws attention to those areas where further study is specially needed.

Lorand's question, 'Should adolescents be analysed at all?' can be answered more and more effectively as psycho-analytic understanding and experience increase. There are by now many analysts whose studies show the positive value and success of adolescent analysis, not only where immediate therapeutic intervention is necessary but even more so from the angle of prevention.

Ilse Hellman

Basic Theory of Psychoanalysis. By Robert Waelder. (New York: Int. Univ. Press, 1960. Pp. 273. \$5.00.)

Those who have not been privileged to know him as an inspiring teacher will find in this book all the qualities that have enabled Robert Waelder to fulfil this role for so many years. His long and intimate involvement with psycho-analysis and his passionate concern for it as one of the great civilizing forces are combined here with his wide culture and capacity to take a broad scientific standpoint. The result is an evaluation presented with a lively urbanity, yet concise and profound, of where the basic theory of psycho-analysis stands today.

Written for a wider audience than students of psycho-analysis, the book will almost certainly be a prescribed text for the latter. To meet in advance the common critical questions of the scientific layman faced with psycho-analysis, the author devotes a first section to the questions of the scientific status of psycho-analytic theories and interpretations. Here he draws on a wide range of views expressed by modern scientists in other fields to show that many of the difficulties confronting psycho-analytic theory are not peculiar to it. While he recognizes that it is not easy to produce answers that are logically satisfactory, it is doubtful if he pursues this whole matter far enough. He does not examine, for instance, whether the way in which many psycho-analytic propositions are made could be revised and possibly put into forms that would permit more refined checking than the usual clinical impression permits. This is a task that has not been tackled hitherto, but might it not be given a new starting point as the result of the

theoretical developments in psycho-analysis? In particular, the new role of object relations in the functioning of the personality would appear to open up possibilities of scientific checking in a way that is precluded by the complications introduced by historical reconstructions. Students of psycho-analysis, as well as others interested, need to have these issues in their minds, and it is salutary that Waelder starts his survey by considering them.

In the second section, there is a brief history of the development of psycho-analytic thought which ends with a reference to the revisionists of recent decades. It is the next section, a 'Survey and Discussion of Basic Concepts', that contains the real meat. To start with, the concept of instinct in psycho-analysis is reviewed and its relations are examined with the uses other scientists have made of this concept. Despite the vivid and stimulating treatment, it can be asked if Waelder has really used the opportunities that the newer biological thinking in this field have introduced. It is not that he ignores these

possibilities; on the contrary, there are, for example, several references to the work of the ethologists. The discussion of drives and of the patterning of human behaviour, however, leaves an impression similar to that left after reading the section on validation, namely, that the appraisal of the present theoretical position lacks an edge to it that could have pointed the way to more satisfactory formulations in regard to energy and structure. The later part of this section covers ego psychology, and this is followed by an interesting review of psycho-analytic treatment, of its relations to other therapies, and of its position when used for conditions other than the neuroses.

What is most impressive about Waelder's book is precisely what will make it widely read by analysts and others, i.e. the way in which he separates the parts of psycho-analytic theory that are basic and presents them for scrutiny against the background of the considerations that led to their evolution.

OBITUARY

MARIE BONAPARTE

1882-1962

Marie Bonaparte was Princess of Greece and Denmark but, more still, was a lady of great scholarship and of great heart.

All aspects of human wisdom awoke in her a passionate curiosity; anything which could attack or wound men's hearts found an immediate and generous echo in her own heart. She could not accept any injustice sustained or inflicted.

She considered it her bounden duty to save Freud from the Nazi régime in Vienna in 1938—she was conscious of all she owed to him, of all that all of us, with her, owed to him. But it was less the sense of an overriding duty than a natural impulse which made her fly to the help of this great man caught in the mesh of a colossal and monstrous injustice. It is therefore thanks to her, helped by Jones, that Freud, already so ill, left the Nazi hell, and it was she again who supervised his settling in England with filial devotion, thus showing the gratitude typical of generous people.

If the tenacity that she brought to the saving of Freud is perfectly understandable in view of her recognition and admiration of him, how can we explain the numerous other cases in which the cruel fate of some unfortunate person aroused in her a fighting compassion which drove her to throw herself immediately into the endless struggle in which some people are engaged against the eternal injustice of the world?

We become accustomed to injustice: it lulls us, it fascinates us, it reduces us to immobility like some slow poison. Marie Bonaparte never became accustomed to it: she did not close her eyes to it, nor yield to it. Few people will believe, for example, that Chessman's fate (to be condemned to death several years ago for rape and led fifteen or more times to the electric chair only to be snatched back from it pending more information), appeared to her so cruel that when there was a question of executing for good this man too long tortured by the procrastinations of a groping judicial system she made the journey personally to ask the governor,

on whom Chessman's immediate fate depended, for his mercy. Perhaps people will also scarcely believe me when I declare that the human indifference which sent Chessman to his death was for her a blow which made her literally ill. To say that she came back with a wounded heart is to speak literally as well as figuratively. When I saw her at that time she was very upset and could not understand the relentlessness which sent the unfortunate man to his death; she refused to admit it and suffered for it as a dishonour which was overtaking man as man. Cruelty perpetrated on a single man or on a hundred thousand men produced in her the same grieving astonishment. In each case she recognized the same face which she hated to such an extent that she wore herself out in a constantly recurring struggle against it. The first manifestations of an illness which weakened her heart dated from that journey, and she was thenceforth unable to resist the illness which was to carry her away with a few days.

But to speak of her great heart and her great character is a long way from exhausting the qualities of such an exceptionally rich personality which is expressed in work of considerable volume and variety. For if she was keenly interested in anything having to do with science she was just as much sensitive to natural beauty. Some of her writings, for instance 'Derrière les vitres closes' or 'L'Appel des sèves' are, quite apart from their psychological and autobiographical interest, full of a poetical charm in which one can see her profound feeling for nature.

As for her scientific curiosity, which she had doubtless inherited from her father, she was always eager, always on the look-out. Consequently, guided also by a strong intuitive sense, she became one of the first in France to recognize and to defend the new aspect of truth revealed by psycho-analysis. It seems that she was at once aware of its immense importance. At that time it required courage to take sides as she did in favour of a science which was

still arousing hostility and general misinterpretation. But we know that she did not lack courage. She threw herself valiantly into the fray, her enthusiasm kindled by the search for a truth which had to be found in the confusion and complexity of man's mental life. Psychoanalysis offered her a tool for making new, audacious investigations. She learnt how to use the new knowledge and did so with remarkable sureness. Her *Edgar Poe* remains one of the monuments in psycho-analytic literature, and I do not doubt that it will hold as much interest for generations to come as it does for us now.

The list of Marie Bonaparte's psycho-analytic work alone would fill several pages. Here I will limit myself to a mention of those which seem most characteristic of her individuality. From *Introduction à la théorie des instincts*, through *Female Sexuality*, to *Psychoanalyse et Biologie* or *Psychoanalyse et Anthropologie*, Marie Bonaparte never loses sight of the human being caught between biological exigencies and environmental demands. (Here I am presenting summarily and in a few words what deserves a much more profound analysis.)

Let us take the well-known example of fertility, in which the fertilized cell is broken apart by the fertilizing cell, as one sees in the case of the ovum penetrated by the sperm. Marie Bonaparte thought that the sexual act was, for the unconscious of the man and the woman, the repetition of, or the equivalent of the biological process. Now this biological movement operates in a calm tranquillity, on condition that this is psychologically accepted and assumed. And it is here that, for the individual, the social factor, the influence of the environment, intervenes. Marie Bonaparte rightly saw in these two essential factors, so often opposed, the determining causes of the underlying conflict which is responsible for the development of character—a conflict which can lead to different degrees of

psychopathological deviation. We find this view again in her interesting studies on criminology.

In my opinion the most original aspect of her work, that which she has truly marked with the seal of her own personality, is to be found in the *Five Copy-Books*, rightly famous, and in an unparalleled article, the 'Identification d'une fille à sa mère morte'. Like Freud, she did not hesitate to unveil what was most intimate in her and sometimes also painful to express, with the sole aim of serving science. Here we have the most precious writings of all, put to the service of psycho-analysis.

Thus Marie Bonaparte lived a full life with zeal, rich with all that she could draw from it and all that she gave to it. The Société Psychanalytique de Paris knows what it owes to her and will never forget her. Let Princess Eugénie and Prince Pierre know that we judge the loss they have sustained by how much we valued her.

I had the privilege of spending several hours with her a few days before her death in the house in the south where she liked to spend some months each year. We had an intimate and friendly conversation together and I found her mind as alert as ever, curious as always and as always overflowing with study projects and work. She even took notes in the course of our conversation connected with something she wanted to write about the poet Walt Whitman. So many projects . . . and already her days were strictly numbered. Had she known the hour of her death she would doubtless still not have given up living as if she was going to live for ever—for love of life and in defiance of death. May her memory find here the homage of a friend who admired in her above everything the ardent courage which is the prerogative of the noble spirit.

S. Nacht

URGENT NOTICE

CONTRIBUTIONS TO 23rd INTERNATIONAL CONGRESS, STOCKHOLM
The Editorial Group of the Journal wish to publish as full an account as possible of the Scientific Proceedings of the last Congress, in Parts 2-3 of the 1964 volume.

Would all those who have not yet sent in their papers, and all those who contributed to the discussions who would like their contribution to be considered for publication, please send manuscripts *immediately* to the Editor at 63 New Cavendish Street, London, W.1.

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123RD BULLETIN OF THE INTERNATIONAL PSYCHO-ANALYTICAL ASSOCIATION

EDITED BY

ELIZABETH R. ZETZEL, HONORARY SECRETARY

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EDITORIAL COMMENT

Following receipt of the letter from Dr Jules Masserman on the Neo-Analytic Movement—published in the 122nd Bulletin of the International Psycho-Analytical Association—the Editor received a letter on the same question from Drs Franz Alexander, Roy R. Grinker, Sr, and Sandor Rado. This letter has, however, already been published as an editorial in the *Archives of General Psychiatry** and it has therefore been decided that it is not necessary to re-publish it in the Bulletin of the International Psycho-Analytical Association.

The Presidential Address, 23rd International Psycho-Analytical Congress, "On the Present Scientific and Social Position of Psycho-Analysis," is included in this number of the Bulletin, as is the list of Officers of the Association elected for 1963/65. The remainder of the Report on the 23rd International Psycho-Analytical Congress will be published in the 124th Bulletin, January 1964.

Also included in this present number of the Bulletin is the Report of Scientific Activities of Component Societies, August 1961 to July 1963. In recent years the Bulletin has published detailed reports in this connexion. The material received this year, however, indicated that with the expansion of scientific activities due first to the development of international meetings, and second to the increased numbers of component groups, the listing of papers and meetings had become both bulky and uninformative. It has therefore been agreed that reports of this nature should be discontinued. Instead, a condensed report, noting new or significant developments, has been compiled, and it is this report that we publish now.

We take this opportunity to advise the membership that the 24th International Psycho-Analytical Congress will be held at Amsterdam, Holland, July, 1965.

Presidential Address
23rd International Psycho-Analytical Congress

MAXWELL GITELSON

President of the International Psycho-Analytical Association

ON THE PRESENT SCIENTIFIC AND SOCIAL POSITION OF PSYCHO-ANALYSIS

As members of society and of one of its healing professions, we once learned and more or less accepted the paradoxical necessity for controlling the impulse which expresses itself as therapeutic ambition. However, it seems to have been more difficult for us to resist the temptation to extend ourselves in areas of social commitment beyond our expertise as psycho-analysts. Under the pressure of the conditions of our times, we have engaged

ourselves in various socially meliorative activities which have undoubted ethical appeal but are not psycho-analysis. Applications of psycho-analysis have become so numerous that it has become difficult to be certain where the boundaries of psycho-analysis lie.

Another aspect of the current social situation in which we tend to reach beyond our scope is research. In the strictest view, research pertains to science.

But science has become a part of the social fabric. Turn where you will and in the name of social need the plea for research is heard. No one will doubt the greatness of the need; but there are many other factors which enter into the wish to respond to this plea, and I propose to discuss some of them which affect psycho-analysts and psycho-analysis.

The time may be appropriate to propose a counsel of modesty for psycho-analysts. I suggest that we have become too ambitious and expansive. The intrinsic potentiality of psycho-analysis as a science is no longer enough. Conscious and unconscious factors are converging in psycho-analysts to obscure their view of themselves as scientists and as members of society.

As scientists we do not maintain the distinction which exists between our area of scientific focus and that of the cognate sciences. We speak of 'applications' of psycho-analysis when often we are engaged in making *extrapolations* based on analogies and assumed continuities. We tend to forget that we have a specific area of competence in individual psychology, and that this is based on the discovery of the peculiar psychological phenomena which come into view in the context of a peculiar dyadic relationship. It seems necessary to reaffirm that whatever we know with relative certainty about these phenomena, whatever we can predict about them with fair probability, whatever we can verify with reasonable confidence through the supporting observations of our psycho-analytic peers, stems from the peculiar experimental field which has become known as the psycho-analytic situation. I shall make a tautological assertion but one whose cogency compels it: only in the psycho-analytic situation do psycho-analysts occupy their explicit scientific position for studying their proper material—the unconsciously emerging manifestations of instinct, primary process, affects, conflicts, defence mechanisms, and transferences.

One of the factors which has led psycho-analysts to extend themselves beyond their scope is the astonishing advance that has occurred in the physical sciences, and the consequent acceleration of the rate at which their data have been accumulating. This has stirred the earnest hopes of workers in other fields, but it has also generated attitudes of competitive inferiority. The prestigious results which have followed from the suitable and necessary methods of the physical sciences have made them the criterion of all scientific research. The wish for similar achievements has become intense and the efforts directed towards attaining them sometimes verge on the frantic. And psycho-analysts too have caught the fever.

It is being overlooked that science is not simply a particular procedure and technology; that in essence science is a point of view stemming from commitment to logical integrity in the search for truth; and that the position of a particular observer, taken up for the study and understanding of particular phenomena,

is of secondary importance in a definition of science. It is a biologist to whom we can turn for a retrieval of this situation.

In an article in the American journal *Science*, George Simpson (1963), Professor of Vertebrate Paleontology at Harvard, says about the classical canons of the scientific method that important basic research has seldom really followed them exactly as they have been stated. Quoting James Conant (1947), he defines science as 'an interconnected series of concepts and conceptual schemes that have developed as the result of experimentation and observation and are fruitful of further experimentation and observation'. This definition, Simpson says, is 'freer and more impressionistic' than the classical formulation by Karl Pearson, but 'to that extent it more nearly covers the varied gambits of research.' Its main virtue is 'its recognition of the role of speculation, intuition, or just plain hunch in finding a hypothesis.'

In the light of the tendency of psycho-analysts to depreciate their technique, of great interest is Simpson's statement that 'science . . . is self-testing by the same kinds of observations from which it arises and to which it applies.' (italics mine.) This is its deductive aspect as stressed by modern writers on scientific method. To this Simpson adds that: 'a fundamental, though not sufficient criterion of the self-testability of science is repeatability . . . the data of science are observations that can be repeated by any normal person.' (italics mine.) 'Normal' in Simpson's context of course refers to the normality of the capacity for perception in a person of adequate intelligence. But it permits us to infer, in respect to the psycho-analytic situation as a valid area of scientific interest, that 'normal' is inclusive of the special kind of capacity for perceiving which is the qualification of the psycho-analyst. Thus the data of the psycho-analytic situation are also subject to 'observations that can be repeated by any "normal" person.' And even if unique events occur, 'evidence on them is acceptable if there is confidence that anyone in a position to observe them [i.e., "anyone" who is "normal" as defined] would have observed them.'

I shall make one more point in this effort to clarify the intrinsic scientific qualifications of psycho-analysis. In the observation of many phenomena, Simpson says, it is not their exact measurement, nor the determination of their occurrence, that is the issue, but the establishment (to some degree of confidence) of probability within a certain range. For it is impossible to prove anything in the natural sciences with the finality of a mathematical proof. Instead we are dependent on the multiplication of relevant observations. The key word is 'relevant.' Relevant observations are such as could disprove a hypothesis. They must be made within a narrowing range of probability. Given these conditions, the more observations fail to disprove a hypothesis, the greater the confidence in it. This is the most common and

conclusive process of self-testing among the natural sciences.

Predictability is a special case of such proof. Thus when psycho-analytic hypotheses are applied in the psycho-analytic situation we may correctly deduce the appearance of certain consequences. Their non-appearance would disprove the theoretical assumptions on which the deduction was based. On the other hand their appearance would not be proof either, but it would certainly increase confidence. Predictability, however, is not the crux of a scientific theory. We see this, for example, in the theory of organic evolution: prediction has not entered into its establishment; it is based entirely on 'relevant' observations. Similar criteria of 'proof' obtain in other fields that have a temporal and historical quality, for instance the time-linked process in geology. Here also operational observations have produced theories based on what one might call developmental reconstruction. These are *process theories*, and all of them have produced numbers and varieties of observations which are consonant only with them and with no other theories. Psycho-analytic theory meets these conditions.

The point of all this is that our view of the nature of science as a whole has been biased because of the historical primacy of the basic physical sciences. But now we are faced by the fact that modern physicists have found that at least some of their laws are not invariable; predictions are approximate; some observations cannot be made; and absolute proof of a hypothesis by testing it cannot always be obtained. Though it has been generally assumed, it is not necessarily true that uniform phenomena have absolute constants, measurable to any degree of accuracy. Biologists have long been aware of this state of affairs without seeing it as contradicting causality and orderliness in nature (Simpson, 1963). It is for this reason that I have outlined for you some of the evidence for the scientific position of psycho-analysis in the context of a definition of science which is not limited to 'cut and dried methods [which] work in particular instances.' (Simpson, 1963.) When psycho-analysis is viewed in terms of the criteria I have presented (and I have not exhausted these!) it qualifies as a valid branch of science.

Nevertheless, there are numbers of analysts who tend to doubt this.

There has been wide discussion of the scientific problem presented by the 'unobjective' quality of the psycho-analytic procedure. One of the more well-disposed and perceptive non-analytic commentators on psycho-analysis, Alan Gregg (1953), has stated that 'in psycho-analytic research the findings are more intimately affected by the researcher than is the case in any other field. [While] that does not *ipso facto* make them less reliable, it does make them less easily verifiable and more open to qualification and rejection.' John Benjamin (1961) has spoken similarly: 'First order conviction based on

private and semi-private interpretations of evidence gained from experience may well be wrong,' he says, 'by virtue of the limitations of the human intellect in dealing with data without the help of painfully learned methods of avoiding erroneous conclusions.' Nevertheless Benjamin's "first order" experience with psycho-analysis has enabled him to say of such convictions that they have often proved to be significantly correct.

Analysts, of course, know something about the countertransference factors operating to impair the capacity for observation, and to produce lapses and distortions of memory; and they have recognized the resulting damage to the basic data of psycho-analysis. Psycho-analytic theory and technique is suitable for making some corrective allowances for this. However, various technological procedures have been proposed, and some indeed are being used with hope of *really* 'objectifying' the psycho-analytic method and improving its 'first order' observations (Carmichael, 1956; Renneker, 1960; Shakow, 1960). But in so doing, a new psychological variable is introduced which changes the very nature of the psycho-analytic situation and thereby the field of observation. These objectifying techniques in their employment of a monitor, human or gadget, subvert the basic principle of the psycho-analytic situation—the dependence of transference on the sustained privacy of the dyadic relationship. Furthermore, these technological methods are no more exempt than are psychoanalysts from what Kubie (1953) has called the fallacy-proneness of man as an instrument. Films, sound tracks, and tapes do not interpret themselves. They too need to be 'observed,' and then the observations are at least once removed from the first-order data which are the proper business of the psycho-analyst.

The problem of objectivity is an old one, and generally present. Claude Bernard (1927), comparing the experimentalist, the scholastic, and the metaphysician, pointed out that 'all [are] subject to the same internal human laws, plagued by the same emotions, prejudices, and biases, and these operate equally in the philosopher and the scientist.' Much later, Richard Tolman (1943), the great physicist, speaking of 'the effect of personal biases on results,' referred to the fact that the scientist 'selects his problem . . . not to obtain results . . . but to satisfy his own subjective needs . . .' Tolman affirmed that ' . . . that which has objective validity is finally abstracted out from the welter of subjective experience in which scientists as well as other human beings are immersed.'

It seems that we are caught in a vicious circle. For it is not only the psycho-analyst who ought to submit himself to correction for lack of complete objectivity in his work. If there is credibility in what Claude Bernard and Tolman and other scientists have said about the fallibility of the human operators of scientific instruments, then even 'objective' investigators of psycho-analysis are bound, at

least in fairness, to be submitted to objectifying scrutiny. The paradox is that this can be done properly only by the use of the very method whose lack of objectivity it is wished to correct. How can we calibrate the subjectivity of the 'objective' investigator of psycho-analysis without the instrumentality of the fallible psycho-analyst?

Let us now consider the interdisciplinary nexus of which psycho-analysis had considered itself a part long before the burgeoning of the idea among other scientists interested in the study of man. Whether it be biological impulses from whatever source, or environmental stimuli of whatever class, there is unconscious resonance in the id which tends toward action discharge under the regulation of the ego and superego. Thus it may be said that all behaviour, under whatever circumstances, is the legitimate concern of the psycho-analyst (Glover, 1956). Psycho-analysts, therefore, could not deny the contingency of their field to academic psychology and education, to sociology and anthropology, to biology and the medical sciences. And they have not done so. On the other hand, the *success* of psycho-analysis in establishing its cogency to all of the sciences which I have mentioned, as well as to psychiatry and the various humanistic fields, is an aspect of the problem which I now wish to discuss.

Psycho-analysis finds itself in a period of history characterized by anxiety. The totalitarian trends of our time affect us from several sides (Bettelheim, 1963). We ourselves have become fearful of what I have called the 'cruel robot' of the unconscious (Gitelson, 1962) as we see it operating with apparently inexorable force in the world around us. Perhaps the clearest example of the reality which stimulates our free-floating anxiety is to be found in the calculating machines which the new applied science of cybernetics has produced. Norbert Wiener (1949) has said of these machines that their aura of uncanniness is related to the fact of the real danger we sense in them: For 'such machines . . . may be used by human beings to increase their control over the rest of the human race; or political leaders may attempt to control their populations . . . through political techniques as narrow and indifferent to human potentiality' as the machines themselves. Associated with such social sources of anxiety is the intra-psycho-anxiety of exposed isolation. The latter is reflected in the political aspects of the social situation in the form of a prevailing tendency to find protection through participation in mass movements and in popular associations. The consequences in the work of the psycho-analyst are the same, only more subtle.

I think that analysts are being tempted to back away from the uniqueness and isolation characteristic of their work. Besides this, the social situation to which I have just referred is intensifying the longing for contact and reassurance. Interdisciplinary participation seems to be in significant part a

manifestation of this. Rationalized as a technique for the exploration of the organic place of psycho-analysis amongst the other sciences of man, it seems that the interdisciplinary idea has become a remedy sought for unconscious disturbance produced by social anxiety. As such the idea is a phantasy of mergence.

Psycho-analysis, we have heard, is not sufficiently objective. And it is proposed to change this by corrective cooperation with the other human sciences. The idea is to collaborate, to check on psycho-analytic method, data, and theory by exposure to other methods, data, and theories; but the unconscious wish, I think, is to merge with a larger whole. And at what cost to psycho-analysis? Rather higher than the idea is worth! Without wishing to turn away from the necessity and the ultimate possibility of refining our method and the logical structure of the theory derived from it, I think that too often interdisciplinary cooperation in its present form has meant the dilution, if not the total disappearance, of essential principles, and the loss of the explicit functional identity of psycho-analysis. That identity derives from the centrality of the concept of the *unconscious* in psycho-analysis; it is this which becomes fuzzy and indistinguishable from what in analysis is known as 'preconscious'; in extreme instances it disappears altogether in some form of purposive reflexological theory.

The trend which I have been describing is responsive to the anxious impulse to join the herd; but it is supported by the mobilization of defensive intellectuality (Gitelson, 1944). Analysts forget the incredible leap forward in our knowledge of the nature of man which followed on the breakthrough into the unconscious. Many are troubled and puzzled by the fact that one great leap has not been followed by another, and another; that the last twenty-five years have not matched the discoveries of the first twenty-five. Some seem to have reacted with an attitude of ennui—a sort of battle fatigue that befalls the victor; while others find reasons to doubt what has been achieved and feel impelled to look for adjuvants. We need to consider the possibility that the same anxiety-provoking social factors which revive phantasies of naked destructiveness are making necessary a search for a means of shoring up what looks like a failure of repression. Not forgetting the logic of the view that psycho-analysis is, at least, one of the main roots of its cognate sciences, I think one must still consider that the forms taken by its excursions into and collaboration with these sciences can represent an intellectual flight from the unconscious.

The problems I have been discussing exist within the body of psycho-analysis. They are to be found among psycho-analysts who, more or less, still adhere to the general idea of psycho-analysis despite anxiety which produces reactive doubt and discontent (Gitelson, 1956). However, my thoughts would be incomplete without considering some

developments which are looked upon as belonging to psycho-analysis but differ from it in important respects. I refer to the cultural, the interpersonal, the biodynamic, and the adaptational theories. Allowing for the fact that they represent the views of some psycho-analysts, the group as a whole is known as 'neo-analysis'. These theories have one thing in common—the change which they make in the concept of the unconscious. While certain recognitions of its phenomena survive in vestigial form, it is this central idea of psycho-analytic psychology which suffers the most.

It is clear enough how this has eventuated in the theories which are based on the several types of environmentalism. They ignore the fact that culture, both in its interpersonal and social aspects, passes through perception-consciousness into the unconscious and mobilizes its forces. But the effect is more subtle and sometimes less easy to recognize in theories which, taking off from Freud's biological orientation, wind up psychologizing constitution, physiology, and reflexology, and turn to animal experimentation as a valid test of human psychology. In their context that which is the dynamic unconscious of psycho-analysis becomes identical with the subliminal somatic states which are in fact a part of the internal environment of the id (Glover, 1956).

Another difficulty with the environmentally and somatically based psychological systems which have developed as alternatives to psycho-analysis is that these too rest on 'convictions,' to use Benjamin's term. As such they are no more susceptible to proof, according to the classical canons of research, than is psycho-analysis (Waelder, 1963; Zetzel, 1963). The issue is not that it is objectionable to try to apply tests derived from contingent sciences to psycho-analytic observations and conclusions. But the mere substitution of a plausible theory does not serve that purpose. 'Convictions remain convictions whether they are positive or negative (Benjamin, 1961); and the 'test' of any conviction which is called 'psycho-analytic' resides in the psycho-analytic situation. Psycho-analysts must consider environmental and somatic factors; indeed they need to be deeply informed about them to appreciate their influence on the id, and through this on the ego and superego. But they are not as such the subject matter of psycho-analytic investigation; they are not part of the psychic system which is its focus of interest.

Something must now be said about 'dynamic psychiatry' and dynamic psychotherapy' (Benjamin, 1961; Gitelson, 1951). These had their beginnings in the United States. The historical and social factors which produced them have intrinsic validity and humanistic appeal. The problem is that their development has been a factor in the changes taking place in psycho-analysis.

Dynamic psychiatry is a mixture of Meyerian psychobiology, educational and social psychology, and American cultural values, to which psycho-analytic personality theory has been added. 'Unconscious motivation' and the classical formulations of 'psychosexual development' are taken for granted. Among the more sophisticated the so-called 'dynamisms' are also appreciated. These elements are eclectically combined in the treatment of mental illness. Dynamic psychotherapy, on the other hand, is less eclectic. It is in fact a highly modified derivative of psycho-analysis, directed towards limited therapeutic goals. At its best it can be very good; but not infrequently it is wild analysis.

In neither of these developments can we discern the possibility of disciplined scientific method. Both are greatly dependent on the artistry of the practitioner. In neither do we find a format for self-testing repeatability of first order observations. Both lack an intrinsic scientific theory: the first is a pragmatic mélange of clinical ideas; the second is a clinical application of the psycho-analytic theory which made it possible. In addition, even good 'analytically oriented' psychotherapy must assume, as a matter of operational principle, that 'unconscious motivation' is really preconscious. Furthermore it calls for a range of 'flexible' accommodation to the so-called 'needs'—more often wishes—of the patient which changes the field of observation from the externalized manifestations of the intrapsychic into a social-interpersonal field.

I do not make these statements as criticisms of valid and frequently quite successful psychological interventions. I mean to emphasize, however, that psycho-analysts involved extensively in this useful area of therapeutic activity tend to lose sight of its difference from their work in the psycho-analytic situation, of which the touchstone is the continuous operation of the dynamic unconscious and of resistance to it. The necessary and unavoidable 'flexibility,' and the limited goals of psychotherapy produces a shielding of the unconscious such that the relevant observations and first order convictions of psycho-analysis are lost.

I must touch on one more aspect of the unconscious repercussions of the anxiety of our times which have resulted in alloplastic phenomena of still another kind among psycho-analysts. No one has forgotten the anxiety and guilt with which physicists reacted to the production of the first atomic bomb. We are aware of the sequel to that reaction—the magnificent mobilization of the social consciousness of scientists. We are also aware of two other consequences: the moral enlistment of some scientists in the service of the forces that have been let loose,¹ and the overshadowing of pure research by massive concentration on technological applications of its results. This is not the time to

¹ See the writings and public statements of Herman Kahn and Edward Teller as examples.

attempt an elaboration of the psychological ramifications of these consequences. For the present purpose it is enough to suggest that in this state of affairs we may recognize the basic need which drives man to substitute activity for passivity. No analyst will be unaware of the adaptive usefulness of this; nor doubt the moral validity of its role in the altruistic aspect of man's nature. But neither may we overlook its aggressive-defensive aspects in the presence of anxiety. The impulse is to 'do something'!

Once, when I was being excessively active with one of my early patients, one of my teachers said to me: 'Doctor, when there are two people in the same room and one of them is anxious or in despair, it helps a great deal if the other is not.'¹ I think that this is a counsel whose observance is useful not only in the psycho-analytic situation but also on the larger scene which analysts face today. As responsible members of society we have every reason for deep concern and for sophisticated participation in the events of our time. The problem is to differentiate between this and our identity as psychoanalysts. I think there is a tendency to move from competent function in our professional and specific scientific roles into active coping with our own anxiety by way of some of the active applications to which psycho-analysis is being diverted *in its own name*.

I hope I have made clear what I meant at the beginning when I proposed a 'counsel of modesty.' It is really a counsel of self-respect. This is gratuitous advice, as any advice is bound to be when the basic problems are unconscious in each of us. In the course of my discussion I have made various allusions to these deeper psychological factors. It is necessary, however, that I say something more about them.

Those who take psycho-analysis seriously obtain from it the satisfactions inherent in any creative work. But there are unique stresses involved in this work which have special effects on the psychoanalyst (Grinberg, 1963). The problem of the mental hygiene of psychoanalysts has not been, and perhaps cannot be, fully solved, despite the fact that the preparatory analysis is intended to be a foundation for it, and often is. The practice of psycho-analysis is a lonely business. There is probably no endeavour which makes greater demands on the capacity to be alone. Drastic reduction in consensual communication is conducive to regression beyond what is technically useful in the service of the analyzing ego. Infantile sources of stimulus-hunger are revived; the need for "narcissistic supplies" is aroused; the compensatory wish for participation in, and active control of, the external world is intensified. The analyst's immersion in the unconscious produces a kind of agoraphobic separateness which makes it

important for him to find somewhere some fenced-in common ground with others. Add to this the guilts and disappointments which attach to the difficulties of the therapeutic task, and it would be surprising indeed if there were no disillusionment, no need for validation in the eyes of others, no hankering after conventional scientific fraternity, no wish to be safely bound by ordinary rules and methods.

Such elements in the analyst's emotional position are, of course, variable in their intensity and effect. In a given instance any one of them is only more or less important; the overall situation may be in relative balance by virtue of the nature of the analyst's original commitment to his career, his basic capacity for continued self-analysis, and his libidinal investments in his private life, his professional associations and activities, and his social and cultural interests. When this balance is threatened a need to redress it arises. One of the manifestations of this need may be a change in the course of the psycho-analytic career.

A critique such as I have attempted should not leave you with the impression that we should adhere to the *status quo*. The self-respect of which I have spoken is the security of knowing and accepting intrinsic potentialities, and limitations. It means remaining open to surrounding possibilities, while not forgetting their discrepancies. It is a balance between flux and stability. It is historical identity and the capacity to tolerate developmental change. It is the ability to stand alone and to be with others. Finally, it is the capacity to tolerate uncertainty and to await the outcome rather than to wish for and search for omnipotent solutions. In short, self-respect is the maturity which we strive for in ourselves and welcome in our patients. However, as we know, these attainments are relative. And the same may be said for our extended role in psycho-analysis as teachers, educators, and investigators. There are things that we need to look to in ourselves.

Beginnings have been made in recent years. In the scientific area we have begun to look at the logical gaps in our theory, at its need for better systematization, and at its semantic confusions (Rapaport, 1960); in the educational field we are beginning to think about the inconsistencies in our training procedures with our theory and the clinical principles we have derived from it (Lewin and Ross, 1960). These developments are evidence of a self-scrutiny which speaks for awareness of questions to be asked, and of answers that need to be found. The questions are generic to our special field of interest and their answers must be found within its context.

But there are other aspects of our situation which do not match these developments. They arise from individual sources that coalesce into a general

¹ Lionel Blitzsten (1893-1952) first Chicago psycho-analyst and teacher of many leading American psychoanalysts. Obituary in *J. Amer. Psychoanal. Assoc.*, 1.

effect. When we venture into other fields, we tend to extrapolate beyond the limits of our own definite knowledge in these fields. As teachers there is a tendency to be authoritarian and paternalistic when we could afford modesty and tentativeness. As training analysts it is difficult to avoid the kind of investments in the careers of our analysands which produce defects in the resolution of the transference neurosis. Surviving ambivalence in the student may thus lead to passive acquiescence to psycho-analysis or, on the other hand, to rebellious and sometimes brilliant departures from our field.

On such matters there is much more that we could say to each other; and I think one day we should do this. But for the present I must end with a repetition of the closing comment in my published communication of last autumn (Gitelson, 1962): 'There is reason for interminable self-analysis for each of us, not merely as individuals, but also in our function as members of groups which are responsible for passing on the torch of self-knowledge which we received from Freud.'

Stockholm,
29 July, 1963.

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OFFICERS OF THE INTERNATIONAL PSYCHO-ANALYTICAL ASSOCIATION

Result of Elections held at the Business Meeting of the Association held on 31 July, 1963, at Stockholm

HONORARY PRESIDENT (continuing):

HONORARY VICE-PRESIDENTS:

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REPORT OF SCIENTIFIC ACTIVITIES OF COMPONENT SOCIETIES AUGUST 1961 TO JULY 1963

Activities in an International Level

The trend towards scientific and educational co-operation between scientific groups in different Continental areas is expanding rapidly. The following organizations, either formally or informally constituted, have come to our knowledge:

1. The Latin-American Congress;
2. The proposed Pan-American Congress;
3. Meetings of Psycho-Analysts in the Romance languages;
4. Meetings of Psycho-Analysts in the German language;
5. Meetings of European Training Analysts;
6. Coordinating Committee of the Latin-American Psychoanalytic Associations.

The following reports have been submitted:

The 23rd Congress of Psycho-Analysts in the Romance Languages was held in June 1962. This meeting was organized by the Luso-Spanish Society. The French and Luso-Spanish Societies participated.

The Third Meeting of Middle European Associations in the German language was held in Murten, Switzerland, in April 1962.

The European Training Committees met in

Murten, Switzerland, in April 1962. The purpose of these meetings is to become better informed concerning problems in the different European countries.

The Fourth Congress of Latin American psychoanalysts was held in Rio de Janeiro in June 1962.

The coordinating Committee of the Latin American Psychoanalytic Associations was organized in 1960 with the following goals: (a) to plan a curriculum for all Institutes in Latin America; (b) to raise the standards of Institutes and improve communications. Since the last Congress, this Committee has held two meetings—in June 1962 and February 1963. At the second of these meetings an appointed Committee of the American Psychoanalytic Association took part. These meetings have been mainly concerned with planning the First Pan-American Psychoanalytic Congress which will be held at Mexico City in March 1964.

Reports on the Activities of Component Societies American Psychoanalytic Association

The American Psychoanalytic Association reports that three of its Committees have been engaged in scientific work during the period September 1961 to August 1962.

1. The Committee on Continued Study of Central Fact Gathering Data. Dr David H. Hamburg, Chairman of the Committee, reported in May 1962 that the previous investigation had produced valuable results, especially in the area of 'the sociology of (our) profession.' He stressed that 'two . . . misconceptions . . . should be corrected: (1) that the reporting analysts . . . indicated poor treatment results; and (2) that the . . . material is being suppressed.' 'The project,' he stated, 'had been an act of responsibility of a professional association; it is a 'sort of experience survey.'

2. The Committee on Indexing and Classification of Psychoanalytic Literature. This Committee was established by the Executive Council first as an *ad hoc* Committee under Dr David Beres, and then as a permanent Committee under Dr Mark Kanzer. It has developed three major projects of its own: (a) A subject-heading index; (b) A survey of clinical indexes; (c) A classification arrangement for libraries.

3. The Committee on Psychoanalytic Education. Dr Jacob A. Arlow, Chairman, reports that after the completion of the survey of Psychoanalytic Education in the United States, two things became clear: first, that many Institutes could benefit from advice and consultation about their educational practices and from information about practices employed in other Institutes; second, that there are many unsolved problems in psycho-analytic education which deserve intensive long range study. Among these problems are: curriculum, selection of students, the role of supervision, problems concerning training analysts, selection and training of teachers and training analysts, etc.

Dr Samuel Guttman, the new Chairman of the Program Committee of the American Psychoanalytic Association, initiated at the Fall Meeting 1962 a new form of scientific meeting—namely, the Workshop. On the first occasion two Workshops were held: (1) on Psychosis; (2) on the Contributions of Melanie Klein. These Workshops are limited to approximately 20 participants selected from the panel of those who express an interest by the Program Committee and the Coordinator of the Workshop. The first venture proved, on the whole, rewarding. In addition to Workshops of theoretical subjects, clinical Workshops for case discussion were initiated at the Annual Meeting in St Louis.

Affiliate Societies of the American Psychoanalytic Association

Association for Psychoanalytic Medicine (New York)

This group has been very active in community relations and problems relevant to nuclear warfare. A new category of Research Affiliate has recently been established. The Association is now in the process of organizing a library.

Baltimore Psychoanalytic Society

Twelve presentations were reported. The majority of the subjects clearly related to psycho-analysis.

Boston Psychoanalytic Society and Institute

Scientific meetings have been held on a monthly basis. A symposium on Narcissism took place in April 1962. The reorganization of the Society Institute is well under way. A Joint Committee on Reorganization has presented a preliminary draft of a new Constitution. The Committee on Organization of the Educational Committee has formulated new bylaws.

Chicago Psychoanalytic Society

Six scientific meetings were reported, as well as a panel discussion on Transference in Children.

Cleveland Psychoanalytic Society

This Society reports ten scientific meetings.

Denver Psychoanalytic Society

This Society was organized in April 1962 and became an affiliate society of the A.P.A. in May of the same year. No scientific programme has been reported at the time of this report.

Los Angeles Psychoanalytic Society

Nine presentations and five research seminars were reported. The Extension Division continues active participation in community activities. Case Seminars for Probation Officers, lecture workshops on educational subjects, and a series of lectures for social workers have been held.

Michigan Association for Psychoanalysis Inc.

Eight scientific meetings were reported.

New Jersey Psychoanalytic Society

This Society has held four scientific meetings and a panel discussion.

New Orleans Psychoanalytic Society

This Society reported seven meetings in 1961–62 and four in 1963. The titles reflect an interest in general topics.

New York Psychoanalytic Society

The ten scientific meetings reported concerned themselves with specific psycho-analytic subjects. Dr Phyllis Greenacre gave the Freud Anniversary Lecture on 'The Quest for the Father—a Study of the Darwin-Butler Controversy.' In addition, the Institute continues five research projects on: (1) Suitability for psycho-analytic training; (2) Subsequent careers of rejected candidate applicants; (3) Study of recordings of conferences of the affiliate staff of the Psychoanalytic Clinic; (4) Prediction of suitability for analysis; (5) Four Studies were

continued on: (a) the Sense of Identity; (b) Depression, its clinical and theoretical aspects; (c) Psychoanalysis and Learning Theory; (d) The unfolding of the analyst's understanding in the psycho-analytic situation.

Philadelphia Association for Psychoanalysis

The Association reports eight meetings. Dr Bertram D. Lewin gave the Freud Anniversary lecture on 'Knowledge and Dreams.'

Philadelphia Psychoanalytic Society

Six meetings are reported.

Pittsburgh Psychoanalytic Society

Four meetings, at which guest speakers presented, were reported.

Psychoanalytic Association of New York, Inc.

Six meetings are reported as well as a panel on 'Ego Psychology and Mythology.'

San Francisco Psychoanalytic Society

The Extension Committee of the Society organized a large number of courses for social workers, psychiatrists, other physicians, and State hospitals. The completion of the Society building is rapidly approaching. Six scientific meetings are reported.

Seattle Psychoanalytic Society

This Society was host to the West Coast Analytic Societies meeting. The Training Center is in the process of evaluation for Institute status.

Society for Psychoanalytic Medicine of Southern California

This Society held five general meetings and three quarterly research meetings. Considerable interest in applied psycho-analysis is evident. The Society and Institute sponsored, together with Cedars of Lebanon and Mt. Sinai Hospitals, and the University of Southern California, a scientific symposium celebrating Franz Alexander's seventieth birthday.

Topeka Psychoanalytic Society

Seven meetings are reported.

Washington Psychoanalytic Society

This Society reports seven meetings. The programme indicates considerable interest in general subjects.

Westchester Psychoanalytic Society

This Society reports five meetings. In the Fall of 1962 the postgraduate Study Group was established to concentrate on 'Criteria for Analyzability.'

Western New England Psychoanalytic Society

A low-cost clinic for psycho-analytic treatment has been established. Six scientific meetings are reported.

North America other than the A.P.A.

Canadian Psychoanalytic Society

The Tenth Anniversary of the Canadian Psychoanalytic Society was celebrated at the time of the 49th Annual Meeting of the American Psychoanalytic Association in Toronto in 1962. The Prados Essay Prize was established in honour of Miguel Prados for his contribution to the formation of the Society.

Mexican Psychoanalytic Association

This Society has actively participated in the Latin American Psychoanalytic meetings. In addition, a varied programme of 14 papers is reported. Other scientific activities consist of comments on films and general discussion.

South America

Argentine Psychoanalytic Association

1961-62: The annual symposium was devoted to the work of Melanie Klein. 1962-63: An extensive lecture course for friends of the Society is noted. Eleven members of this Society have also made contributions. Two round table discussions are noted.

Brazilian Psychoanalytic Society of Rio de Janeiro

Six presentations are reported.

Brazilian Psychoanalytic Society (São Paulo)

This Society held four meetings with psychoanalytic societies of São Paulo. A series of lectures was organized at the request of the medical students of the University of São Paulo on 'Fundamental Principles of Psycho-Analysis,' which were attended by 400 persons.

Chilean Psychoanalytic Association

Seven members gave papers and discussions concerning clinical problems. One member gave 36 lectures at the Centre of Psychosomatic Medicine. Another gave 24 on child guidance problems for laymen; another, 10 lectures to mothers of the professional classes.

Colombian Psychoanalytic Society

Five scientific meetings were reported. In addition, a number of other papers were presented on general subjects.

Rio de Janeiro Psychoanalytic Society

The members of this Society have been very active in participating in the Latin American Psychoanalytic Congress. Several members also participated in the Third Latin-American Congress of Group Psychotherapy in July 1962.

Uruguayan Psychoanalytic Association

This Society participated in the 4th Latin-American Congress. One of its members also took part in the Latin-American Congress of Group Psychotherapy.

*Europe**Belgian Psycho-Analytical Society*

This Society reports four meetings, and a symposium on Acting Out, during 1961-62.

British Psycho-Analytical Society

1961-62: The Society reports nine scientific presentations, four papers for the Membership Panel, and group discussions on a number of topics. The Clinical Essay Prize was shared, in 1961, by Dr F. T. Lossy for 'The Charge of Suggestion as a Resistance in Psycho-Analysis,' and Dr H. Tausend for 'The Analysis of a Special Resistance in an Oral Character.'

1962-63: Increase in membership was found to put strains on the procedure for scientific meetings, traditionally held in plenary session. As a result, a series of experiments was made, including the simultaneous presentation of papers to smaller groups, and the reporting of simultaneous discussions by several groups of a single paper. These and other experiments are being currently evaluated by the Society. Also, four Research Workshops have been set up: (a) on Concepts; (b) on Dynamics of specific Psycho-Analytical Situations; (c) on Research Problems; (d) on the Phenomenology and Ecology of typical occurrences in psycho-analysis. A programme of scientific meetings and seminars was organized by the Society prior to the 23rd International Psycho-Analytical Congress. The 50th anniversary of the foundation of the London Psycho-Analytical Society, the first psycho-analytical society in England, will fall on 30 October 1963, and celebrations will take place during the ensuing year, including, on 20 February 1964, an oration by Dr W. H. Gillespie entitled 'The Contributions of the British Psycho-Analytical Society to Psycho-Analysis,' to which colleagues from all Component Societies are welcomed and invited.

Danish Psycho-Analytical Society

The Danish Society reports six meetings. Several discussions of general topics were reported.

Dutch Psycho-Analytical Society

This Society reports 13 presentations given by the Amsterdam and The Hague sections. The Institute is engaged in finishing its research on 'Prognosis and Effect.' A new section has been organized in Groningen.

German Psycho-Analytical Association

Ten papers were given at the Berlin Institute, 7 by members and 3 by foreign guest speakers. In Hamburg, a Seminar was conducted by two Dutch analysts and one German participant on treatment

techniques with neurotic patients, while Dr Willi Hoffer spoke on Curative Factors in Psycho-Analysis. The Psychosomatic Clinic in Heidelberg, and the Institute and training centre for psycho-analysis and psychosomatic medicine in Frankfurt, organized a lecture series on a variety of theoretical topics. The participants were predominantly members of the Dutch and British Societies. Dr Hans Zulliger gave 20 sessions on psycho-analytic observations in normal and pathological puberty in boys.

Italian Psycho-Analytical Society

Twenty papers were reported. Several visiting psycho-analysts gave lectures.

Luso-Spanish Psycho-Analytical Society

Nine papers were given.

Paris Psycho-Analytical Society

This Society reports eight scientific meetings. A scientific programme was organized by the Society prior to the 23rd Congress.

Swedish Psycho-Analytical Society

Three round table discussions were organized. Guest speakers spoke on psycho-analysis in applied fields.

The Swedish Society acted as hosts to the International Psycho-Analytical Association on the occasion of the 23rd International Congress at Stockholm, July-August 1963.

Swiss Psycho-Analytical Society

The Society reports 19 presentations, most of which appear to revolve around clinical material.

Viennese Psycho-Analytical Society

This Society reports nine meetings.

*Asia**Indian Psycho-Analytical Society*

One foreign speaker and 12 presentations are reported.

Israel Psycho-Analytical Society

A number of guests have presented papers to the Israeli Society, which held 14 meetings.

Japan Psycho-Analytical Society

Although the Japanese Society did not submit a report of scientific activities, they completed the preliminary questionnaire on training. It appears clear that an active programme for training in psycho-analysis under University auspices has been established.

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